

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Lester E. Athey						Feb. 16, 1968			2:35A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		Caucasian		10/26/87		80 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
West Va.		USA				Prince Georges Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince Geo. Gen'l Hospital			Ret'd Landscape			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Prince Georges			Hyattsville		2005 Ingraham Street	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
John					Athey	Bertha			Vickers
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
						Eleanor E. Parker Same as Item #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u> <u>4270</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute congestive heart failure.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary edema and congestion, marked.</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4341</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at home		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) <u>attending</u> attended the deceased from <u>Feb. 16, 1968</u> , to <u>Feb. 16, 1968</u> , that (I) <u>saw</u> saw the deceased alive on <u>Feb. 16, 1968</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death.									
22b. SIGNATURE <u>Benjamin S. Miller M.D.</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>16 Feb 1968</u>		
22d. PHYSICIAN'S NAME (Type) <u>Benjamin S. Miller, M.D.</u>					22e. ADDRESS <u>3824 34th Street, Mt. Rainier, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
<u>Burial</u>		<u>2-19-1968</u>		<u>Elmwood Cemetery</u>		<u>Shepherdstown West Va</u>			
24. FUNERAL DIRECTOR <u>Simmons Bros</u>					ADDRESS <u>Wash DC</u>		25a. REC'D BY REGISTRAR DATE <u>Feb 20 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>
24. FUNERAL DIRECTOR <u>Simmons Bros 1661-Good Hope Rd SE</u>									

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

02961

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02947

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH			<input checked="" type="checkbox"/> Month	Day	Year	2b. HOUR
Howard Lawrence Auterback						ESTIMATED <input type="checkbox"/> 2 23 1968						7:30 PM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR	
M	W	16 Dec., 1928	39 YRS.	MONTHS	DAYS	HOURS	MIN.	Month	Day	Year	10:26 PM	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH			12b. KIND OF BUSINESS OR INDUSTRY			
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		PRINCE GEORGES			Unemployed			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince George			Unemployed						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			
Md.			Prince George			Suitland			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			13f. STREET AND NUMBER			
Lawrence H. Auterback			Elsie B. ?			4633 Lewis Ave.,						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No						Dorothy E. Auterback,			5414 Shadyside Ave. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) Laceration of brain												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											Minutes	
(b) Multiple skull fractures												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
2234												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
				9:30 PM 2 23 19 68				Passenger in car which hit pole.				
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.				
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				Street				Marlboro Pike Suitland P.G. Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED				
EXAMINER'S NAME (Type)				John Kehoe, M.D., Riverdale				2-24-68				
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				
Burial				2/28/68				Cedar Hill Cemetery				
24. FUNERAL DIRECTOR				23d. LOCATION (City or Town)				23e. LOCATION (County)				
Robert E. Wilhelm Funeral Home				Suitland, Prince Georges, Md.								
4308 Suitland Road, Suitland, Maryland				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
				DATE FEB 28 1968				Charles Judge				

IN SENATE,  
January 15, 1920.  
REPORT  
OF THE  
COMMISSIONER OF THE  
DEPARTMENT OF  
CORRECTIONS,  
FOR THE YEAR  
1919.  
ALBANY:  
J. B. LEECH, STATE  
PRINTER, 1920.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR		
Elizabeth Ann Baquial						MATED <input type="checkbox"/> 2 29 1968					5:30 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR
female	white	9-2-12	55 YRS.					2 29 1968					6:05 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Md.		U. S. A.				Prince George's		Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
Cheverly			Prince George's Gen. Hosp.			Housewife			Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md.			P.G.			Palmer Park				8122 Sherrill Street			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
Unknown						Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
no			577 46 6286			Pedro D. Baquial			Same as # 12 (husband)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Cardiac Tamponade													
DUE TO, OR AS A CONSEQUENCE OF													
(b) Rupture of Myocardium											minutes		
DUE TO, OR AS A CONSEQUENCE OF													
(c) Myocardial Infarction											one week		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
4201													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
				HOUR A.M. P.M.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED					
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland				ASSISTANT MEDICAL EXAMINER				3-2-68					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town)		(County) (State)			
Burial				3/5/68		Baltimore National		Baltimore		Baltimore Md.			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons						Hyattsville, Md.		MAR 6 1968		Charles Judge			

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(11-11)

*[Faint, illegible handwritten text and markings, possibly a signature or scribble]*

11-11-11

11-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
25M 1/62

02963

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02950

1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u></u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glenn Dale (rural)</u>			c. LENGTH OF STAY IN 1b <u>77 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Glenn Dale Hospital</u>				d. STREET ADDRESS <u>200 6th Street S.E.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Paul</u> First Middle Last				4. DATE OF DEATH Month <u>2</u> Day <u>27</u> Year <u>1968</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/15/10</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rest. Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-----</u>		9. AGE (In years last birthday) <u>57</u> yrs.	
11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Coy T. Barefoot</u>				14. MOTHER'S MAIDEN NAME <u>Ida B. ?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>577-07-6238</u>		17. INFORMANT <u>(Decedent)</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic coma</u> <u>5710</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cirrhosis of the liver</u> DUE TO (c) <u>Chronic alcoholism</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>years</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>5811</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour "a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/13</u> , 19 <u>67</u> , to <u>2/27</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/27</u> , 19 <u>68</u> , and that death occurred at <u>7:25 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Moe Weiss</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/27/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Moe Weiss, M. D.</u>				22d. ADDRESS <u>Glenn Dale Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Mar. 2, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tew Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Glenn Dale, Md.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home 300 4th St. NE Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>MAR 1 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



## CERTIFICATE OF DEATH

02964

04506

1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR A			
Baby Boy Barnett						Feb. Month 28, Day 1968 Year			1:50 M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Negroid		Feb. 27, 1968			YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Maryland		U.S.A.					Prince Georges Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince Geo. Gen'l Hospital									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
Maryland			Prince Georges			Upper Marlboro			Upper Marlboro			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME									
James Henry Owens			Bonita Alice Barnett									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Respiratory Distress Syndrome</u>												
7762 DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) <u>Prematurity</u>												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
773.5												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
			HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION			City or Town County State			
22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>Feb. 27, 1968</u> , to <u>Feb. 28, 1968</u> , that <del>he</del> (we) last saw the deceased alive on <u>Feb. 28, 1968</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death.												
22b. SIGNATURE						DEGREE			22c. DATE SIGNED			
<u>John H. Moling, M.D.</u>									<u>2/28/68</u>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS						
John H. Moling, M. D.						Prince Georges General Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
			3/2/68			Prince Geo. General Hosp			Cheverly, Maryland			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
<u>Harry W. Penn, Jr., Administration</u>						DATE <u>MAR 11 1968</u>			<u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02064

02064

DATE: 10/10/50

TO: Mr. J. Edgar Hoover

FROM: Mr. Clegg

SUBJECT: [illegible]

RE: [illegible]

1. [illegible]

2. [illegible]

3. [illegible]

4. [illegible]

5. [illegible]

6. [illegible]

7. [illegible]

8. [illegible]

9. [illegible]

10. [illegible]

11. [illegible]

12. [illegible]

13. [illegible]

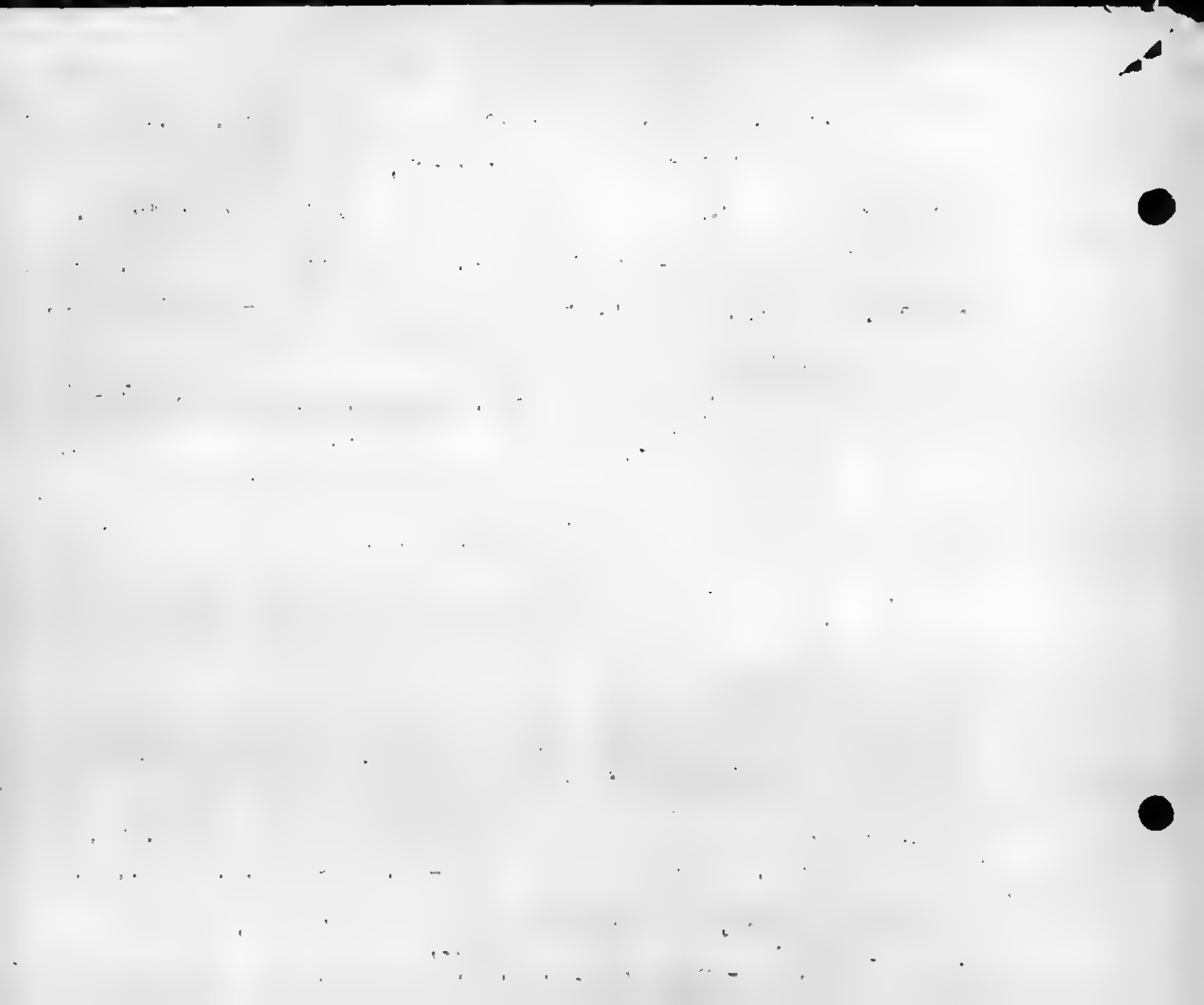
14. [illegible]



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Norwood T. Beach						Month Day Year Feb. 27, 1968		8:45 P.M.		
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		May 8th, 1889		78 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Virginia		USA				Prince George's Co. Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Oxon Hill			2309- Norlinda Ave.			Retired		DC, Transit		
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Pr. George's		Oxon Hill		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2309- Norlinda Ave.	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME			Address				
First Middle Last			First Middle Last							
Unknown			Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT					
					Mrs. Clara V. Beach (Wife) # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cardio-Vascular Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Gastrointestinal Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: <u>5-27-68</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Parkinson's disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-5 min</u> <u>20 min</u> <u>24 hours</u>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1968</u> , to <u>Feb 27, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb 26, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>John W. Price</u>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Feb. 27, 1968			
22d. PHYSICIAN'S NAME (Type) John W. Price					22e. ADDRESS 300- M. Street S.W. Wash., DC.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
Burial		March 1, 68		Cedar Hill Cemetery		Suitland, Maryland				
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>					ADDRESS Wash.		25a. REC'D BY REGISTRAR DATE FEB 29 1968		25b. REGISTRAR'S SIGNATURE <u>Frank J. [Signature]</u>	
Simmons Bros. 1661- Good Hope Rd. SE. DC.										



# FOR STATE HEALTH DEPT

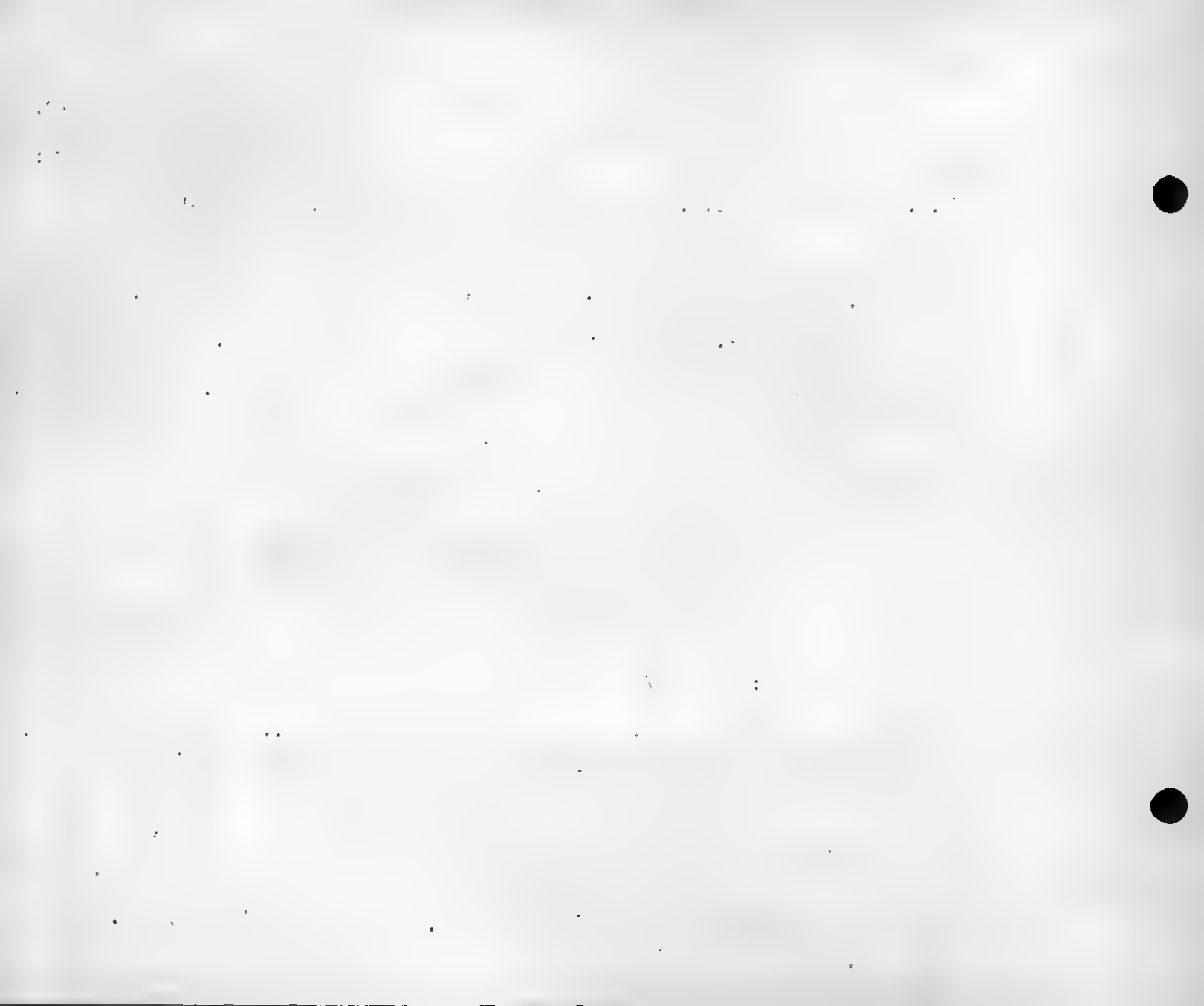
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <b>David Edward Beck</b>			2a DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> 2 18 1968			2b HOUR 12:20 AM		
3 SEX <b>male</b>	4 RACE <b>white</b>	5 DATE OF BIRTH <b>8/24/63</b>	6 AGE (in years last birthday) <b>4 YRS</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 2/ Day 18 Year 19 68		
7a BIRTHPLACE (State or foreign country) <b>D.C.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b>		
10 CITY OR TOWN OF DEATH <b>Riverdale</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Leland Memorial Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Child</b>		12b KIND OF BUSINESS OR INDUSTRY <b>none</b>
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Ma.</b>		13b COUNTY <b>Prince Geo.</b>		13c CITY OR TOWN <b>Riverdale</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>5904 Sheridan St.</b>
14 FATHER'S NAME First Middle Last <b>George F. Beck</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Bette G. Bonbrest</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			16b SOCIAL SECURITY NO <b>none</b>		17 INFORMANT <b>Bette Beck</b>			
			ADDRESS <b>5904 Sheridan St. Riverdale, Md.</b>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Multiple skull fractures</b> DUE TO, OR AS A CONSEQUENCE OF <b>318.1</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b) <b>Trauma from automobile accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 hours</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>44</b>								
19a. DATE OF OPERATION <b>2/17/68</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Multiple skull fractures</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month Day, Year HOUR A.M. <b>7:30 PM 2/17/68</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Child fell out of automobile</b>			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Kennilworth Ave.</b>		21f LOCATION Street or R.F.D. No <b>5460 Kennilworth Ave.</b>		City or Town <b>Bladensburg, Md.</b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>Cornelius J. Burns</b>			M.D. <b>Cornelius J. Burns, MD</b>			22b. DATE SIGNED <b>18 Feb. 68</b>		
EXAMINER'S NAME (Type) <b>Cornelius J. Burns, MD</b>			ADDRESS (Street, city, town, or county) <b>Cheverly, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/21/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>		
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>			ADDRESS <b>Mt. Rainier Maryland</b>		RECD BY REGISTRAR <b>FEB 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>f Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

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MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR
Katie Elizabeth Bell						MATED <input checked="" type="checkbox"/> 2-27-68 199			00pm
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD	2d HOUR
Female	Negro	2-15-1890	78 YRS					Month Day Year 2 27 68	199:25pm M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Prince George's Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince George General Hospital						
13a U.S.A. RESIDENCE (Where deceased lived, if institution)			13b COUNTY		13c CITY OR TOWN	13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland			Prince George		Coral Hills	YES <input type="checkbox"/> NO <input type="checkbox"/>		1408 Boonshill Road	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
John Porter			Mary Young						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS				
					Mrs. Florence Chew-daughter-1408 Boone Hill Road				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure									minutes
DUE TO, OR AS A CONSEQUENCE OF Hypertensive arteriosclerotic heart disease									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			19						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			2-28-68			
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		2/4/68.		Lincoln Memorial Ceme.		Maryland			
24 FUNERAL DIRECTOR John T. Stewart, Jr.					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Stewart Funeral Home-4001 Benning Rd., NE					MAR 4 1968		Charles Judge		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

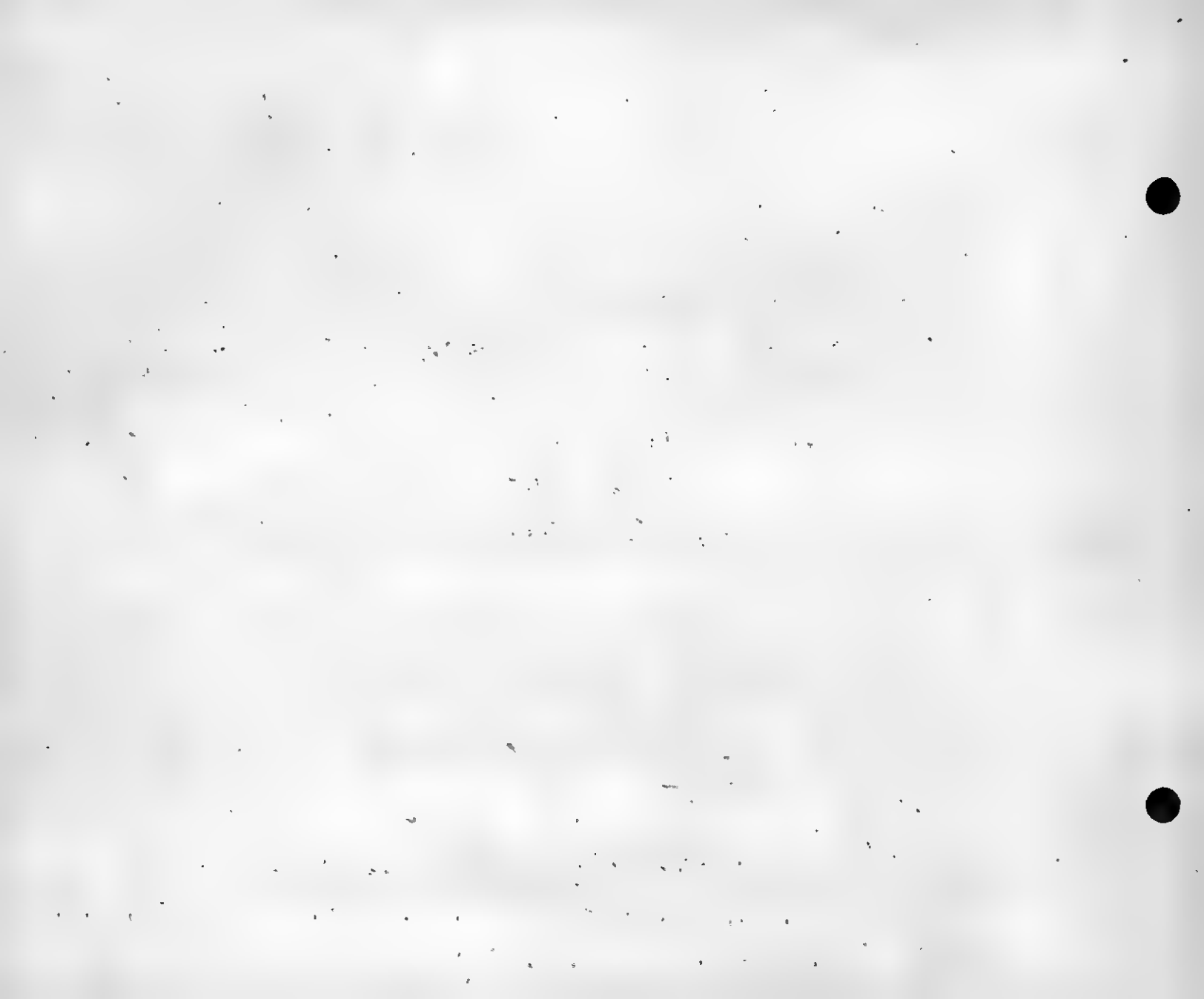
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VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>OLESTA A. BINKLEY</b>			2a. DATE OF DEATH Month <b>Feb</b> Day <b>23</b> Year <b>1968</b>		2b. HOUR <b>12:00 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>2-29-1885</b>		6. AGE (In years last birthday) <b>82</b>	IF UNDER 1 YEAR MONTHS <b>00</b> DAYS <b>00</b> HOURS <b>00</b> MIN <b>00</b>
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges</b> Md		
10. CITY OR TOWN OF DEATH <b>Clinton Maryland</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pine View Gardens</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Molder</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retiree</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b> CITY <b>Prince Georges</b>	13c. CITY OR TOWN <b>Wash. DC.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>N 809 T. ST. SE</b>		
14. FATHER'S NAME First <b>William</b> Middle <b>Leonard</b> Last <b>Leonard</b>		15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>Leonard</b> Last <b>Leonard</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO. <b>4</b>		17. INFORMANT <b>Dr. Alfred R. Lapin</b> Address <b>Clinton Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4109 Coronary occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Cardiovascular Disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minute</b> <b>4 min.</b> <b>2-3 yrs</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>T.B.</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/9</b> , 1968, to <b>2-23</b> , 1968, that (I) <b>(we)</b> last saw the deceased alive on <b>2-23</b> , 1968, and that in (my) <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(we)</b> <b>(did)</b> <b>(did not)</b> view the body after death.					
22b. SIGNATURE <b>Alfred R. Lapin M.D.</b>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) <b>ALFRED R. LAPIN, M.D.</b>				22e. ADDRESS <b>Clinton Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE <b>Feb. 26, 68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Concord Meth Ch. Cemetery.</b>		23d. LOCATION (City or Town) (County) (State) <b>Lewisville, N.C.</b>	
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>		ADDRESS <b>1661-Gd. Hope Rd. SE. Wash. DC.</b>		25a. REC'D BY REGISTRAR <b>FEB 26 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Items 5, 6, 7a & 7b Film G398 3/1/68 kk 02969									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Emma			E. Black			Month Day Year Feb. 26, 1968			4.30 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		April 4, 1882		85 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Ill.		USA				P r. George's Co. Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Upper Marlboro		1755 = Brown Road		Retired		US. Gov.			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Pr. Geo'S Oxon Hill				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		233- Panorama Drive
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
John S. Rudolph			Laura Hust						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
no					Revus R. Black ( Son) Same as # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Exacerbated arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u> <u>5 yrs</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>45c</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>2-25</u> , 19 <u>64</u> , to <u>2-26</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-24</u> 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John B. Fegan</u> M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Feb. 26, 1968			
22d. PHYSICIAN'S NAME (Type) John B. Fegan				22e. ADDRESS 2210- Nichols Ave., SE. Wash., DC.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>March 1st</u> <u>1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Stokes M. E. Chapel</u>		23d. LOCATION (City or Town) (County) (State) <u>Crossville, Ill.</u>			
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>		ADDRESS <u>Wash DC</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 28 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			
Simmons Bros. 1661-Good Hope Rd. SE.									

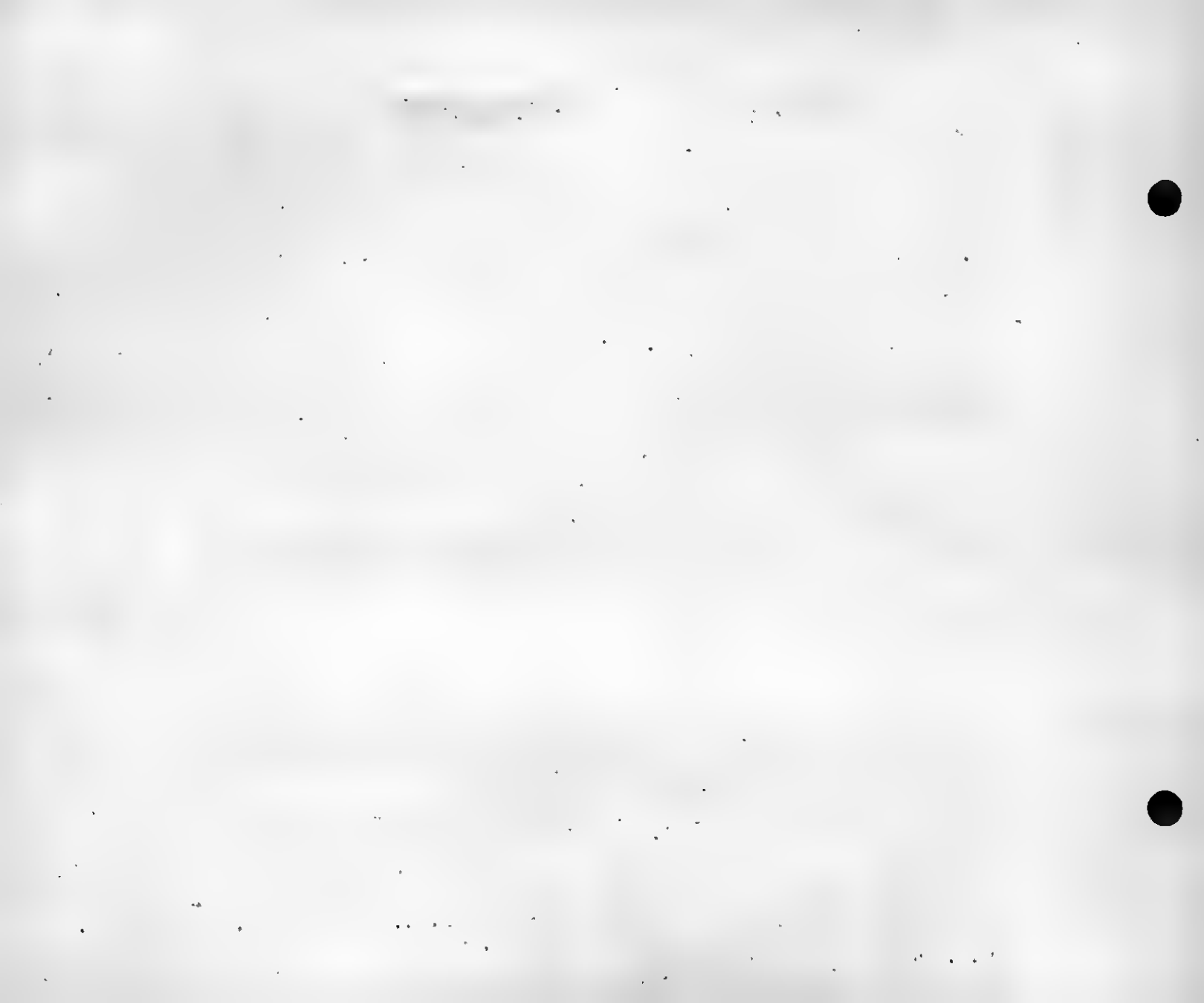
MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1, 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First <i>Hannah</i> Middle <i>Blanford</i> Last <i>Blanford</i>			2a DATE OF DEATH			2b HOUR		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)		
<i>Female</i>			<i>White</i>			<i>12-3-1871</i>			<i>2</i> Month <i>19</i> Day <i>68</i> Year		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
<i>MARYLAND</i>			<i>U.S.</i>						<i>Prince George Md</i>		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
<i>HATTISVILLE</i>			<i>CORREL MANOR 4922 LAUREL</i>			<i>Teacher</i>			<i>School</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
<i>DISTRICT OF</i>			<i>Columbia</i>			<i>Washington</i>			<i>3060 16th ST. N.W.</i>		
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last								
<i>William</i>			<i>Blanford</i>			<i>Agnes</i>			<i>Cleary</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17. INFORMANT			Address		
<i>No</i>			<i>Unknown</i>			<i>A. E. Elizabeth - 4922 Laurel Rd.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <i>Heart Failure, Congestive</i>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <i>Senility</i>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>68</i> to <i>Feb 19, 1968</i> , that (I) (we) last saw the deceased alive on <i>July 29, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS		
<i>Charles W. M. Maurin MD</i>			<i>2/19/68</i>			<i>5415 Hamilton ST - Hyattsville Md</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
<i>Burial</i>			<i>2/22/68</i>			<i>St Johns Church Cemetery.</i>			<i>Clinton Md. Prince George Co Md.</i>		
24. FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
<i>W. K. Huntmann &amp; Son Funeral Home</i>			<i>5732 Georgia Ave</i>			<i>DATE FEB 26 1968</i>			<i>Charles Judge</i>		



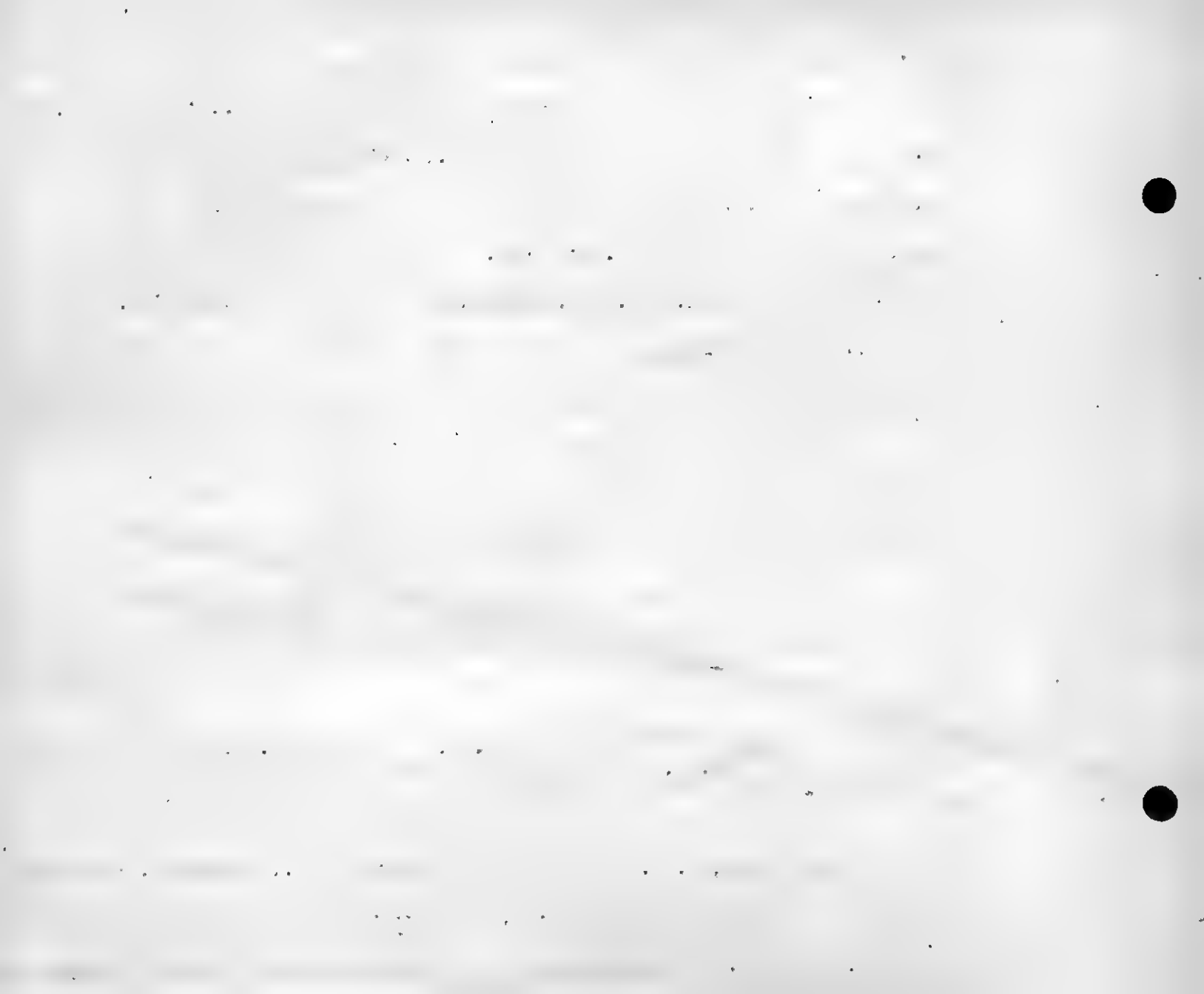


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-4  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Blum			Baby	Boy		Feb., 1 68			2:15AM		
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Male		White		1 Feb., 1968		YRS.		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Prince Georges Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince Geo. Gen Hosp.								
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md			Pr. Geo.		E. Riverdale		YES <input type="checkbox"/> NO <input type="checkbox"/>		6355 64th Ave.		
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First	Middle	Lost
Murray			Blum			Joanne Nicholson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>7777X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>7777X</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <del>(the husband)</del> attended the deceased from Feb. 1, 1968, to Feb. 1, 1968, that (I) <del>(the)</del> last saw the deceased alive on Feb. 1, 1968, and that in (my) <del>(the)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <del>(did)</del> <del>(do not)</del> view the body after death.											
22b. SIGNATURE						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
John Kehoe, M. D.						6300 Riverdale Rd., Riverdale, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
		3/2/68		Prince Geo. General Hosp.		Cheverly, Maryland					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Harry W. Penn, Jr., Administrator						MAR 11 1968		John Kehoe, M.D.			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

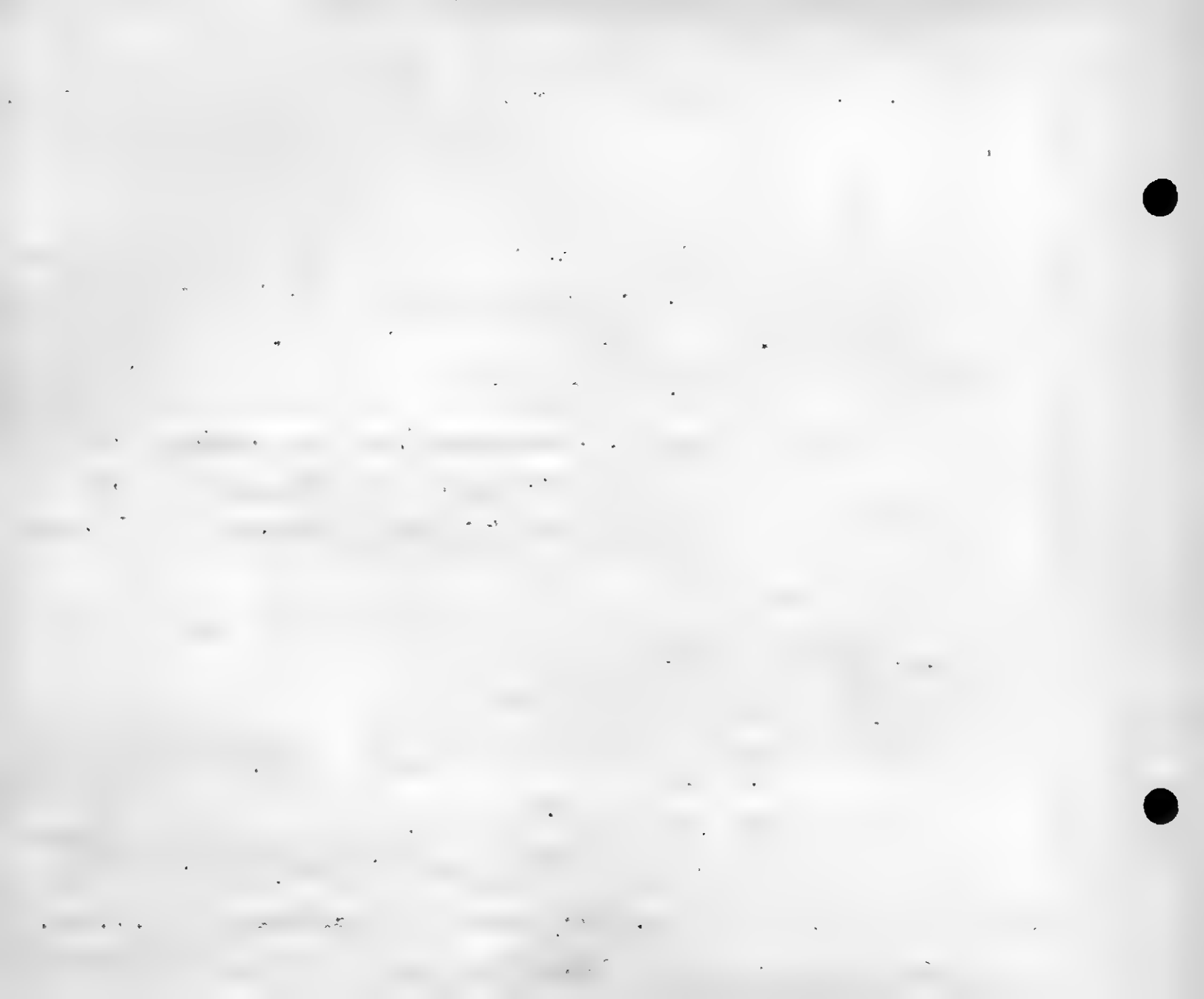
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 15 (4)  
30M REV. 1/68

02972  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

02951

1. DECEASED-NAME (Type or print) <b>Nellie</b>		First <b>I</b> Middle <b>Bohannon</b> Last		2a. DATE OF DEATH <b>2</b> Month <b>28</b> Day <b>68</b> Year		2b. HOUR <b>11:58 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>5/12 '01</b>		6. AGE (In years last birthday) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md			
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Eugene Leland Memorial</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Telephone</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Hyattsville</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>2212 Woodberry St.</b>	
14. FATHER'S NAME First <b>James</b> Middle <b>B.</b> Last <b>Dixon</b>		15. MOTHER'S MAIDEN NAME First <b>Ida</b> Middle <b>L.</b> Last <b>Hutchinson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO <b>214 01 3932</b>		17. INFORMANT <b>hospital records</b>		Address <b>Riverdale, Md.</b> <b>4708 Queensbury rd.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac De-compensation &amp; Pulmonary Edema</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Occlusion &amp; a Thrombus</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic Heart Disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b> <b>36 hours</b> <b>5-10 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 6, 1951</b> , to <b>Feb. 28, 1968</b> , that (I) (we) last saw the deceased alive on <b>February 28, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Walcutt W. Gibson MD</b>				DEGREE <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>February 29, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Walcutt W. GIBSON, M.D.</b>				22e. ADDRESS <b>4300 St. Barnabas Road Marlow Heights, Maryland 20031</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/2/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P. G. Md.</b>			
24. FUNERAL DIRECTOR <b>Francisc Gasch's Sons</b>				ADDRESS <b>Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 4 1968</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 3443. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 2-14-68 192		2b HOUR 04am		
Hayward			W			Bowling				
3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR		
Male	White	9 Oct. 1949	18 YRS			2 Month 14 Day 68 Year 19 2		10am		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
West Virginia		U.S.A.				Prince George's		Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during last week before death)		12b KIND OF BUSINESS OR INDUSTRY		
Riverdale			Leland Memorial Hospital			Gas Station Attendant		Scott Stat ion		
13a USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Prince George		Hyattsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		5301 Hamilton Street Apt. 2	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
Woodrow P. Harless			Gladys Marie Bowling							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS					
no			219 54 5991		Janet S. Bowling Same as #13 (wife)					
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Laceration of brain DUE TO, OR AS A CONSEQUENCE OF (b) Multiple skull fractures DUE TO, OR AS A CONSEQUENCE OF (c) Minutes									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month Day, Year 2:01pm 2-14-1968		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) Passenger in car which struck pole.					
21a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Kenilworth Ave. at Fletchers Field, Edmonston, Maryland		21f LOCATION Street or RFD No City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			2-14-68				
John Kehoe MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
Riverdale, Md.										
23a BURIAL CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		2/17/68		Calfee Cemetery		Berkley West Virginia				
24 FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR DATE		25b REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Hyattsville, Md.					FEB 19 1968		Francis Gasch			





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last <b>Hammond BOYER</b>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 2-10-68 19 5:00pm		2b. HOUR	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 2 11 68 11:25am	
Male	White	18 June 1888	79 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Prince George's Md.			
Md		USA							
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)			12a. USAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Laurel			613 Main Street			Laborer			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Prince George		Laurel				613 Main Street
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William Boyer			Janie Gardner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS		
yes			WWI		218-05-6637		Blanche Leishure, Laurel Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 47-00									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A M P M 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8.)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		2-12-68	
John Kehoe MD			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			2-14-68		Baltimore National		Baltimore Md		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
McWitt			Dorchester, Md			DATE FEB 16 1968		Charles J. Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR	
Mary E. Brown						Feb. 5, 1968		9:05A M	
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Negro		July 7, 1881		86 YRS.			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U. S. A.				Prince Georges Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince Geo. Gen'l Hospital		Housekeeper		Private Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland		Prince Georges		Clinton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8637 Woodyard Road	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			
Patrick Brown						Mary M. Clark			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No					Mrs. Mabel G. Brown-8637 Woodyard Rd., Clinton, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION									
DUE TO, OR AS A CONSEQUENCE OF									
(b) ASHD + RBBB									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)									
42									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (X) (this hospital) attended the deceased from Dec. 10, 1967, to Feb. 5, 1968, that (X) (we) last saw the deceased alive on Feb. 5, 1968, and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
Manuel V. Penasales, M. D.		2-6-68		Manuel V. Penasales, M. D.		Prince Georges General Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/10/68		Resurrection Cemetery		Clinton Pr. Geo Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Ritchie Bros.		Upper Marlboro, Md.		MAR 14 1968		Charles Jones			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
Nathaniel		M		Brown				ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/>		12:30 P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR
M	Negro	5 July 1897		70 YRS	MONTHS		DAYS		Month Day Year		12:45 P.M.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Missouri		U.S.A.		Prince Georges							
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Glendale, Md.		Glendale Hosp									
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, N.Y.S?		13e STREET AND NUMBER			
D.C.		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				2701 24th St., N.E.			
14 FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
DECEASED				DECEASED							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO.				17. INFORMANT			
NO				NONE				Evelyn Jones- 2701 24th St., NE.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										minutes	
Hemorrhage											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last											
(b)										months	
Pulmonary tuberculosis											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
0021											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)							
		P.M. 19									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		John Kehoe				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED			
EXAMINER'S NAME (Type)		John Kehoe, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		2-1-68			
						ADDRESS (Street, city, town, or county)		Riverdale, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial		2-8-68		Church Cemetery		Quincy, Illinois					
24 FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Rheuer 20 3015-12 d 76, Wash. D.C.								DATE FEB 8 1968			

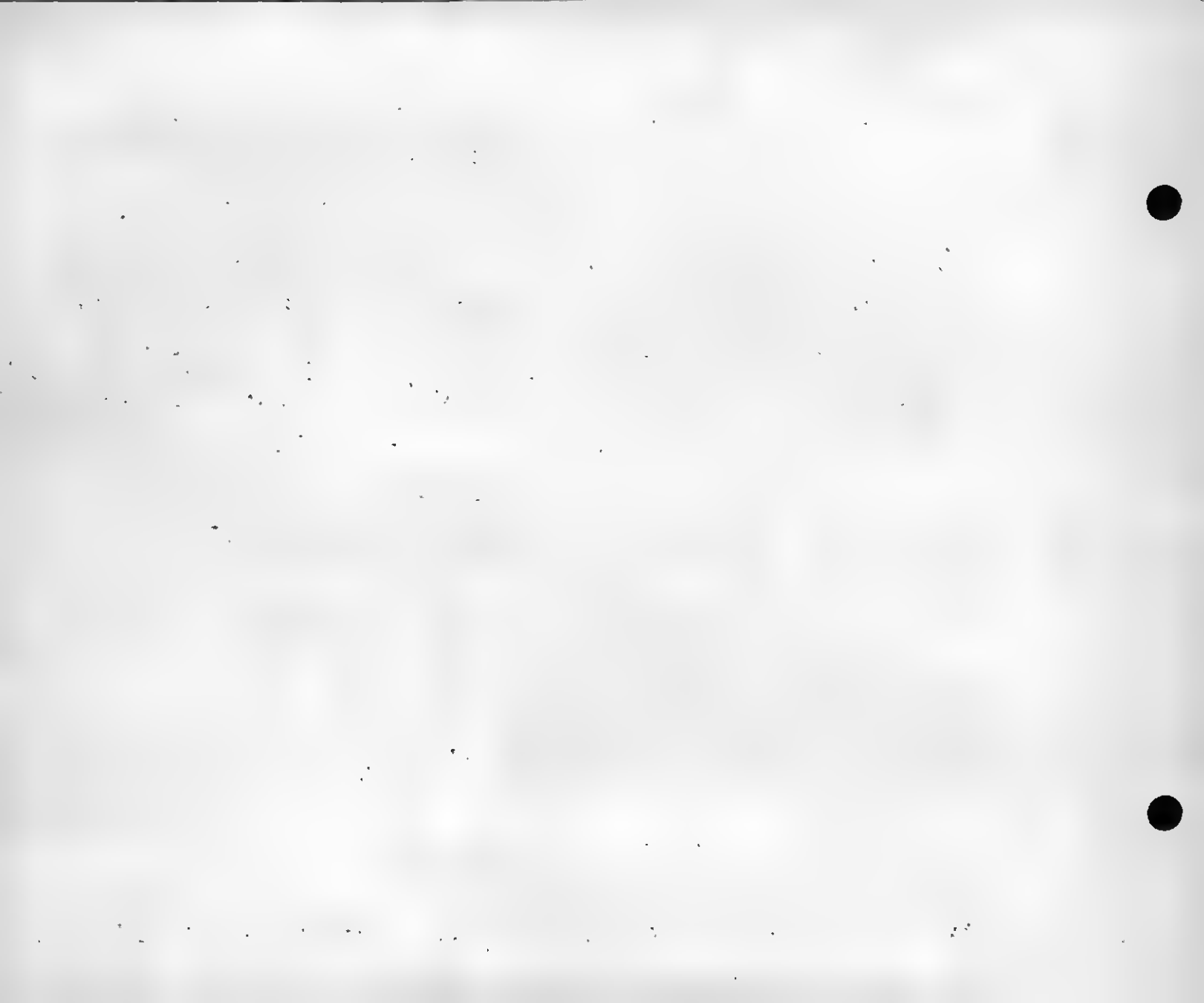


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last LOUIS FRANK BULLEN			2a. DATE OF DEATH Month Day Year FEB 1 1968			2b. HOUR M			
3 SEX M		4. RACE W		5. DATE OF BIRTH SEPT 30 1891		6. AGE (In years last birthday) 76 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) BALTIMORE MD		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGE MD			
10. CITY OR TOWN OF DEATH LAUREL		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CLARK RD			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) FARMER		12b. KIND OF BUSINESS OR INDUSTRY CHICKENS		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE MD		13b. COUNTY PRINCE GEORGE		13c. CITY OR TOWN LAUREL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 2306 CLARK RD	
14. FATHER'S NAME First Middle Last JOSEPH BULLEN			15. MOTHER'S M.A.DEN NAME First Middle Last MARY MEEKS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No			16b. SOCIAL SECURITY NO. 4-201		17. INFORMANT Mrs. Nida L. Bollen				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>coronary arteriosclerosis &amp; Diabetes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 4-20-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-16, 1964, to 1-16, 1968, that (I) (we) lost the deceased alive on 1-16, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Edolo Pierandrea				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 2-1-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2-3-68		23c. NAME OF CEMETERY OR CREMATORY Linden Park		23d. LOCATION (City or Town) (County) (State) Baltimore MD			
24. FUNERAL DIRECTOR Albert H. Hershman				ADDRESS Linden Park		25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE W. J. J. J.	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 6 Film G398 2/29/68  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
 02978  
 CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>PAUL M. BURTHE</b>			2a. DATE OF DEATH Month <b>2</b> Day <b>23</b> Year <b>68</b>			2b. HOUR <b>12:15 P.M.</b>	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>6-13-1899</b>		6 AGE (In years last birthday) <b>68</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>LOUISIANA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGE COUNTY, Md.</b>	
10 CITY OR TOWN OF DEATH <b>BOWIE RACE TRACK</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>FIREMAN</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>FIREMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FIRE DEPT.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b>		13b. COUNTY <b>WASH. D.C.</b>		13c. CITY OR TOWN <b>WASH. D.C.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>5205-KANSAS AVE</b>		14 FATHER'S NAME First <b>LOUIS</b> Middle <b>BURTHE</b> Last <b>BURTHE</b>		15. MOTHER'S MAIDEN NAME First <b>EUGENIA</b> Middle <b>N.</b> Last <b>BURTHE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>NOT AVAILABLE</b>		17. INFORMANT <b>(WIFE) MRS. DOROTHY J. BURTHE</b>		Address <b>5205-KANSAS AVE, WASH. D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.H.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>64 YRS.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4501</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>INSTANT.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>DIABETES MELLITUS; C.A. COLON-RECTUM 1966</b>							
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>—</b>			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>—</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>—</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE, 1962</b> to <b>23 FEB, 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb 23, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>William Howard Yeager Jr. MD</b>		DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-23-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Wm Howard Yeager Jr.</b>		22e. ADDRESS <b>1808 COUN. AVE NW WASH D.C.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2-27-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CONGRESSIONAL CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>WASH. D.C.</b>	
24. FUNERAL DIRECTOR <b>Pei Thomas M. Hyson</b>		ADDRESS <b>1300 N ST. NW WASH. D.C.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

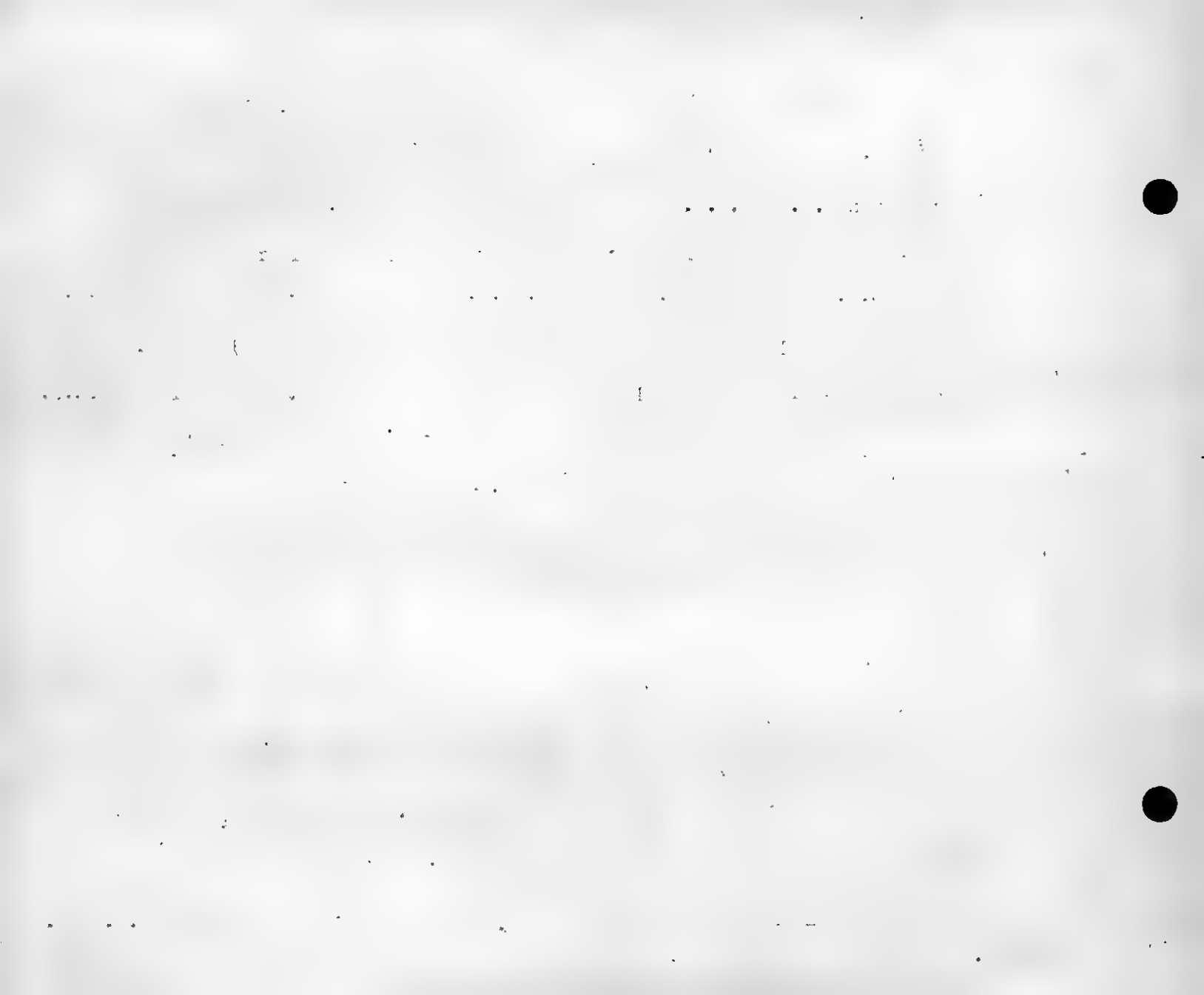
32971

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

296

1. DECEASED NAME (Type or print) <b>Joseph Butler</b>			2a. DATE OF DEATH Month <b>Feb.</b> Day <b>21</b> Year <b>1968</b>			2b. HOUR <b>7:15PM</b>			
3. SEX <b>Male</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>12-29-22</b>		6. AGE (In years lost birthday) <b>45</b> YRS.		IF UNDER YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's General</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Truck helper</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>D.C.</b>		13b. COUNTY <b>D.C.</b>		13c. CITY OR TOWN <b>Wash., D.C.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1020 1st Street, S.E.</b>	
14. FATHER'S NAME First Middle Last <b>Andrew Butler</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Rosa (or Rose) Butler.</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>Yes</b> (If yes give war or dates of service) <b>WW II</b>		16b. SOCIAL SECURITY NO. <b>578 14 6010</b>		17. INFORMANT Address <b>Elizabeth Butler (wife) 1020 1st. St. S.E.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive intracerebral hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>Essential hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>2311</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>2/19</b> , 19 <b>68</b> , to <b>2/21</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>2/21</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>R. Frank</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2-22-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>RUFANCHI</b>				22e. ADDRESS <b>7729 Finck Lane Lanham Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-26-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mem. Park</b>		23d. LOCATION (City or Town) (County) (State) <b>7601 Sheriff Rd. N.E. Md.</b>			
24. FUNERAL DIRECTOR <b>B. H. Hapler</b>				ADDRESS <b>909 6th St. N.W.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



# FOR STATE HEALTH DEPT.

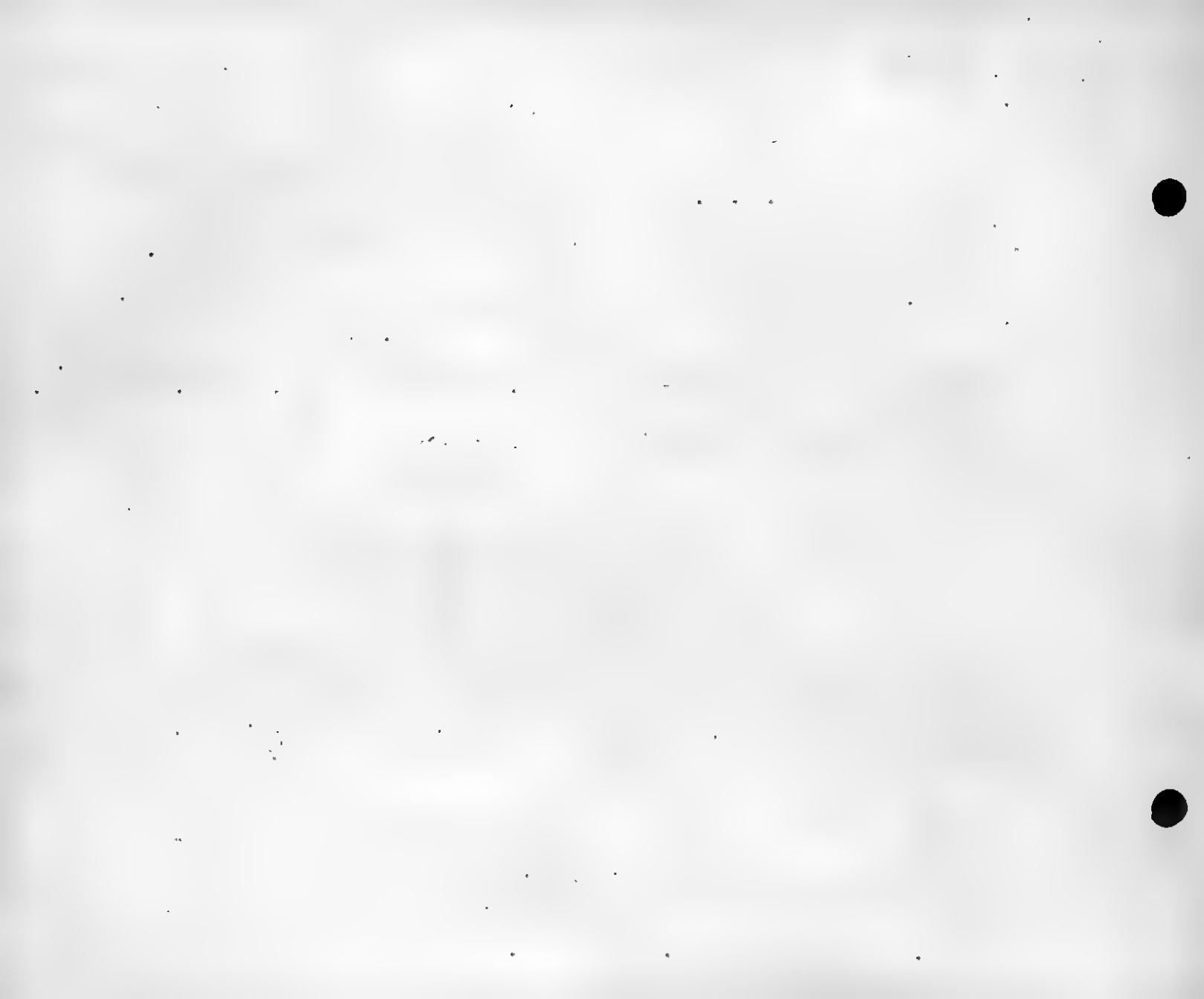
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR		
John Tony Carakoulakis						DATE MATED <input checked="" type="checkbox"/> 2-25-68 193			00		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD			2d HOUR
Male	White	10/23/22	45 YRS	MONTHS	DAYS	HOURS	MIN	Month 2 Day 25 Year 68			3:10am M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH					
West Virginia		U. S. A.				Prince George's Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a U.S.A. OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			George Transfer Co.					
13a USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) - STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Id.			Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER		
									639 Umbra Street.		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		
Anthony Carakoulakis			Mary DeFillippi			Yes			215-12-5734		
						17 INFORMANT (Brother)			ADDRESS Edgemere, Md.		
						Mr. Frank Carakoulakis, 2609 N. Snyder Ave.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple gun shot wounds											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
161X											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			2:40am 2-25 1968			Shot by assailant					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or RFD No			City or Town		
			3412 40th. Place			Colmar Manor, Prince George Co., Maryland			County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASSISTANT MED. CAL. EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER						2-26-68		
John Kehoe MD			Riverdale, Md.			ADDRESS (Street, city, town, or county)					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			2/29/68			Sacred Heart of Mary			Baltimore, Maryland		
24 FUNERAL DIRECTOR						25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE		
John J. Duda, 7922 Wise Ave. Dundalk, Md.						DATE FEB 29 1968			Charles Jones		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 7a, 7b. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
14-15 Film G398  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) Harry LESTER		Middle CHILDERS. Last		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 2-21-68 19		2b. HOUR M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH 1-6-1911	6. AGE (In years last birthday) 57 YRS	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 2 Day 21 Year 68 19 5:35 PM	
7a. BIRTHPLACE (State or foreign country) W. Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md.	
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived if institution residence before admission) - STATE Maryland		13b. COUNTY Laurel		13c. CITY OR TOWN Laurel		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 809 Bond Mill Rd.							
14. FATHER'S NAME First Middle Last Dallas Childers				15. MOTHER'S MAIDEN NAME First Middle Last Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> <u>4120</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Min.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>443x</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Kehoe</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>2-22-68</u>	
EXAMINER'S NAME (Type) John Kehoe MD		Riverdale, Md.		ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>FEB 24, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW RIDGE CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>FAIRFAX, HOWARD Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Stallard</u>		ADDRESS <u>550 WASH BLVD.</u>		25a. RECD BY REGISTRAR <u>Stallard</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Stallard</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

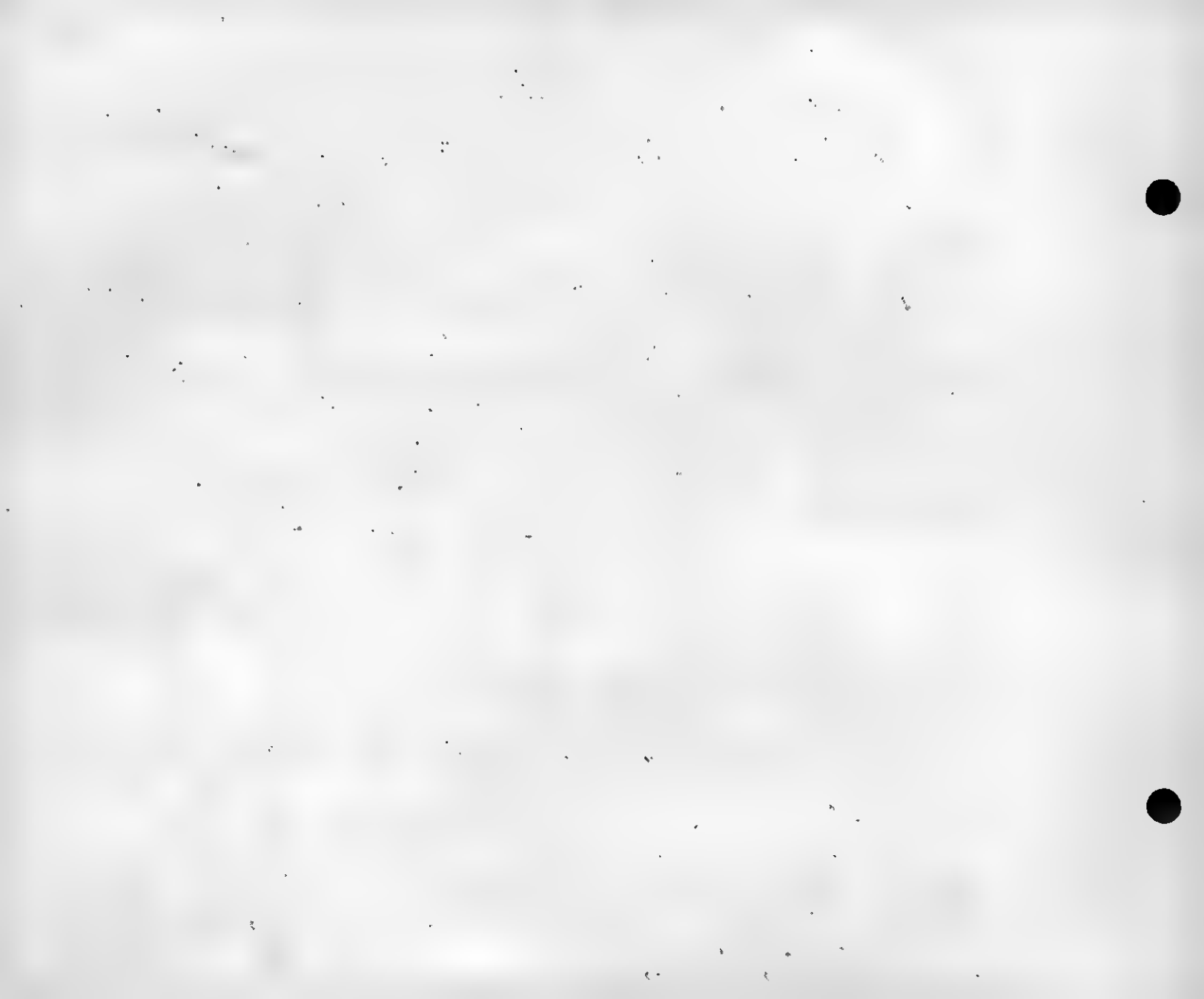
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02982

1967

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	CLINEDINST	2a. DATE OF DEATH Month		Day	Year	2b. HOUR
LULA B. CLINEDINST					2		14	68	5 <sup>12</sup> M
3 SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS
Female	White		9-22-1884		83 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
La.		USA.				Prince George		Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Clinton		Pineview Gardens H		house wife					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Prince George		Hill Crest Hts		YES		5602-28 Pkwy. Hill Crest Hts	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
First		Middle		Last		First		Middle	
Hances Ashbury		Ramey		Lucy Crestia		Belt			
18a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		18b. SOCIAL SECURITY NO.		17. INFORMANT		18c. ADDRESS		18d. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		577-12-513-T		Mrs M. Gimes		Upper Marlboro, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Collapse</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Myocardial Heart Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerosis advanced</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION		Street or R.F.D. No.		City or Town	
22a. I certify that (I) (this hospital) attended the deceased from Jan 17, 1968, to Feb 14, 1968, that (I) (we) last saw the deceased alive on Feb 14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
Alfred R. Lapin M.D.				ALFRED R. LAPIN MD		CLINTON, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
CREMATION		2/17/68		CEDAR HILL CREMATORY		SUITLAND, PRINCE GEORGES, MD.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland				DATE FEB 16 1968		F. Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

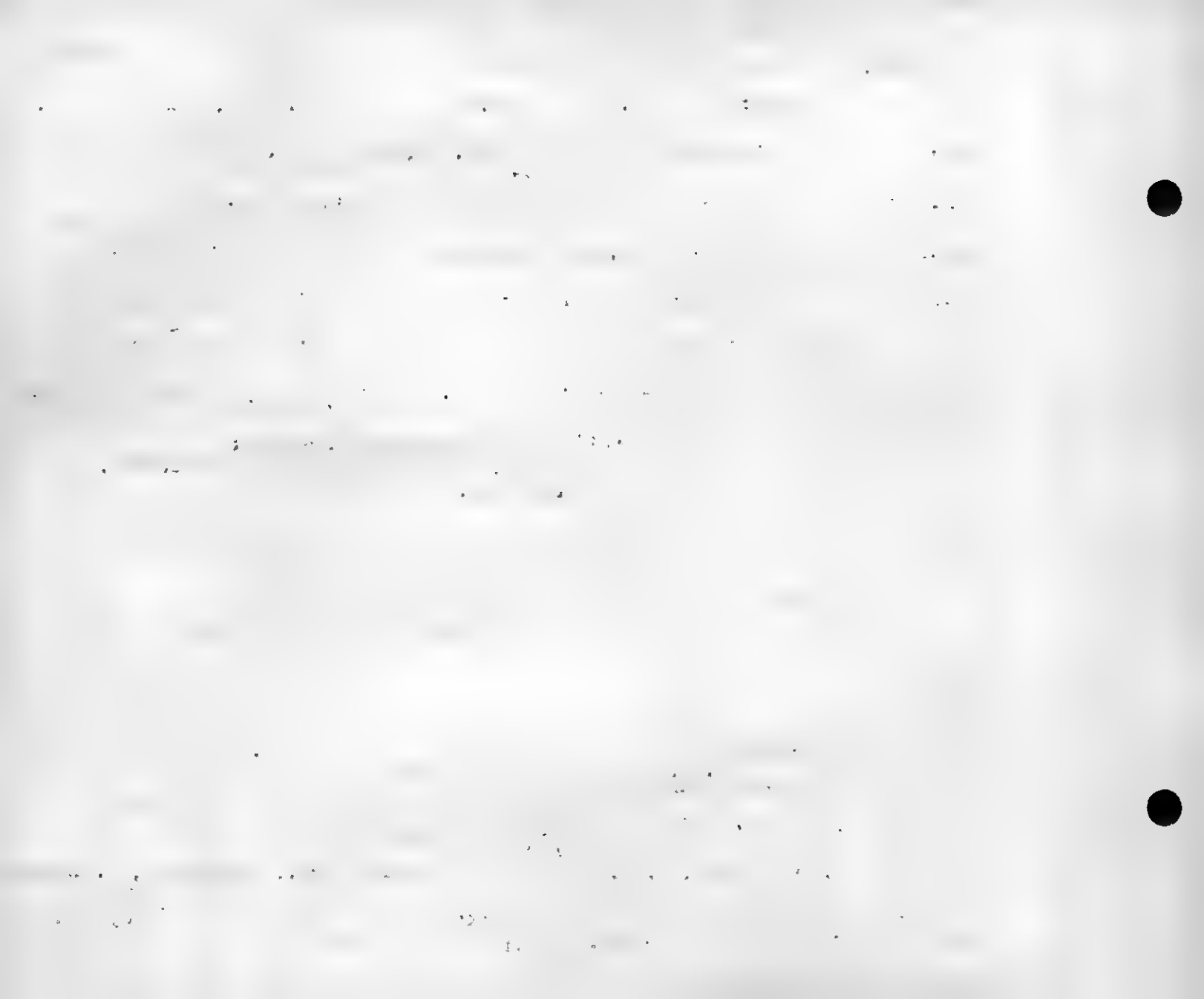
1. PLACE OF DEATH a. COUNTY <u>Prince Georges</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince Geo.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brandywine</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RT. 3 Box 244</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Ralph</u> Last <u>Cooksey</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>28</u> Year <u>1968</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 27, 1907</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Guard</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Library Congress</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Aguasco, Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>James Cooksey</u>				14. MOTHER'S MAIDEN NAME <u>Nettie Richards</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO. <u>577-20-7668</u>		17. INFORMANT <u>Dorothy A. Cooksey</u>		Address <u>RT. 3 Box 244 Brandywine Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension and atherosclerosis</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) this hospital attended the deceased from <u>2-10-68</u> , 19 <u>68</u> , to <u>2-28-68</u> , 19 <u>68</u> , that (2) I last saw the deceased alive on <u>2-28-68</u> , 19 <u>68</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Dobson</u>						22b. DATE SIGNED <u>2-28-68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard H. Dobson</u>		22d. ADDRESS <u>Brandywine, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 2, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Resurrection</u>		23d. LOCATION (City, town or county) (State) <u>Clinton Md.</u>	
24. FUNERAL DIRECTOR <u>The Hunt Funeral Home, Waldorf, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 5 1968</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon, paper, Page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR			
Chester			L. Cooper			Feb. 5, 1968			8 A. M.			
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Male		Caucasian		Jan. 18, 1901			86 7/8 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH					
Virginia		U.S.A.					Prince Georges Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince Geo. Gen'l Hospital			Insurance Agent						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland				Prince Georges		Riverdale		YES <input type="checkbox"/> NO <input type="checkbox"/>		5023 Riverdale Road		
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last								
Charles C. Cooper				Rose V. Price								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No				-		578-09-5161A Mrs. Evelyn H. Cooper (above address) (wife)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease, severe; with acute and old myocardial infarctions.												
(b) Coronary occlusions.												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
42												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from Jan 1, 1968, to Feb. 5, 1968, that (I) (we) saw the deceased alive on Feb. 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Samuel Sugar, M. D.						22c. DATE SIGNED						
22d. PHYSICIAN'S NAME (Type) Samuel Sugar, M. D.						22e. ADDRESS 4637 Eastern Ave., Washington, D.C. 20068						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)				
Burial			2/8/68		East New Market Cem.			East New Market, Md.				
24. FUNERAL DIRECTOR Walley's Funeral Home Inc. Maryland						25a. REC'D BY REGISTRAR DATE FEB 13 1968			25b. REGISTRAR'S SIGNATURE			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
Nannie H. Griddle									MAY 2-23-68 19 8		00am	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR		
Female	White	9-26-1879	88 YRS	MONTHS	DAYS	HOURS	MIN	Month 2 Day 23 Year 68		9:40am		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED		NEVER MARRIED		9. COUNTY OF DEATH		10		
Virginia		U.S.A.		W DOWED		DIVORCED		Prince George's		Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince George Hospital			housewife			none			
13a USUAL RESIDENCE (Where deceased lived, if institution, give street address)				13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13e STREET AND NUMBER		14		
Maryland Prince George Cottage City				YES		NO		3706 37th. Place				
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			
John Hainey							Unk					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT			ADDRESS				
			226 05 7706		May Whiteside Cottage City, Md.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure										minutes		
41 DUE TO OR AS A CONSEQUENCE OF Arteriosclerotic heart disease										over 5 yrs.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
Diabetes mellitus - over 20 years.												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)						
			HOUR A.M. P.M. 19									
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home farm street factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town		County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED			
John Kehoe MD			Riverdale, Md.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			2-23-68			
						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
						ADDRESS (Street city, town, or county)						
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			25a REC'D BY REGISTRAR		
Burial		2-26-1968		Thornrose Cemetery			Staunton, Virginia			FEB 27 1968		
24 FUNERAL DIRECTOR						ADDRESS			25b REC'D BY TRANSFER AGENT			
alley funeral Home Mt Rainier, Md.												





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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print) First Middle Last <b>John A. Curtin Sr</b>			2a. DATE OF DEATH Month Day Year <b>Feb. 1, 1968</b>		2b. HOUR <b>10:25A</b>
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>Jan. 31, 1910</b>		6. AGE (In years last birthday) <b>58</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>Washington D C</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince Georges</b> Md.		
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Brick Layer</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Prince Georges</b>	13c. CITY OR TOWN <b>Mt. Rainier</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>3001 37rd Street</b>	
14. FATHER'S NAME First Middle Last <b>Joseph Curtin</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary C. Bailey</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16b SOCIAL SECURITY NO <b>577 07 5988</b>	17 INFORMANT Address <b>John A Curtin Jr Beltsville, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute renal failure.</b> <b>4121</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Severe sclerosing coronary arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that <del>he</del> (this hospital) attended the deceased from <b>Jan. 31, 1968</b> , to <b>Feb. 1, 1968</b> , that <del>he</del> (we) last saw the deceased alive on <b>Feb. 1, 1968</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death.					
22b. SIGNATURE <i>Wernau dm</i>				22c. DATE SIGNED <b>2-1-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Tomas Hernandez, M. D.</b>				22e. ADDRESS <b>Prince Georges General Hospital</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb 5, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>F. Gasch's Sons Hyattsville, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>FEB 6 1968</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>

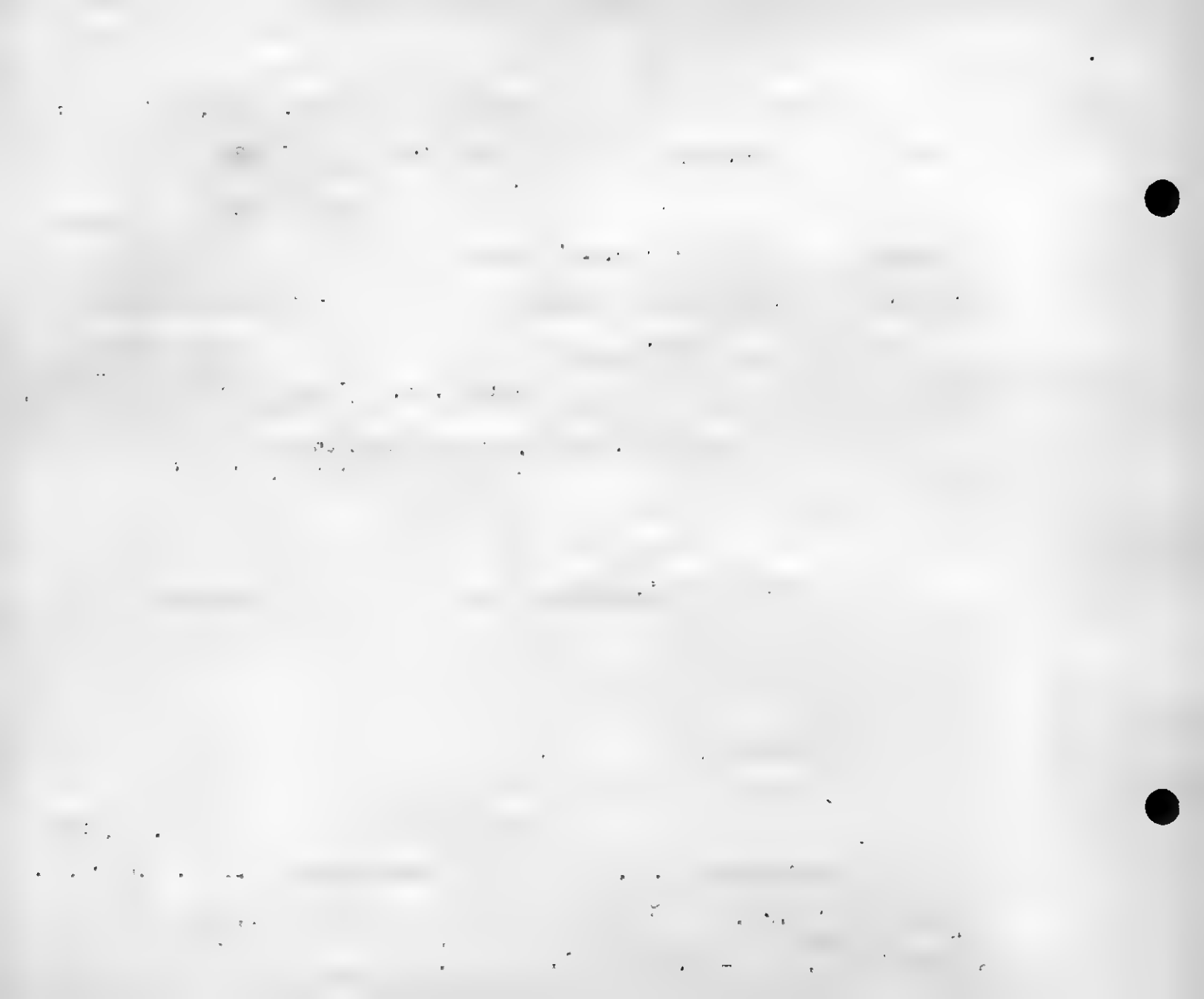


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 7a, 7b, 13c, 13d  
Film G398 3/4/68 ap  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
22987  
MARYLAND STATE DEPARTMENT OF HEALTH  
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>Annie Mae Dalton</b>			2a. DATE OF DEATH <b>Feb.</b> Month <b>22</b> , Day <b>1968</b> Year			2b. HOUR <b>3:35 PM</b>					
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>10/11/94</b>		6. AGE (In years last birthday) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince Georges</b>			13c. CITY OR TOWN <b>Leesburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>305 68th Place</b> <b>A104 Good Luck Road</b>	
14. FATHER'S NAME First Middle Last <b>John Overly</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary McKinney</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		
17. INFORMANT <b>Paul D. W. Dalton (Husband)</b>			Address <b>Same as # 13.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute &amp; Chronic Pyelonephritis with renal abscesses necrotizing papillitis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>6000</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pulmonary Thrombo-emboli, right</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from <b>1967</b> to <b>Feb 22, 1968</b> that (I) (we) last saw the deceased alive on <b>Feb 22, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Leon Levitsky, M. D.</b>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>Feb. 23, 1968</b>				
22d. PHYSICIAN'S NAME (Type) <b>Leon Levitsky, M. D.</b>					22e. ADDRESS <b>3408 Rhode Island Ave., Mt. Rainier, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 26. 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>				
24. FUNERAL DIRECTOR <b>Simmons Bros.</b>					ADDRESS <b>1661-Gd. Hope Rd. SE. DC</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last <b>Edward G Dameron</b>						2a. DATE OF DEATH Month Day Year <b>2 - 9 1968</b>			2b. HOUR <b>7:40 P.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>5-18-1894</b>		6. AGE (In years last birthday) <b>70 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS <b>70</b>		IF UNDER 24 HRS. HOURS MIN. <b>40</b>	
7a. BIRTHPLACE (State or foreign country) <b>McMurry, Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Clinton Md. Prince Georges Md.</b>					
10. CITY OR TOWN OF DEATH <b>Clinton Md</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pine View Gardens Time Keepers</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even retired.) <b>Time Keeper</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>HOTEL</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Chesapeake</b>		13b. COUNTY <b>Charles Cobb Island</b>		13c. CITY OR TOWN <b>Charles Cobb Island</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
14. FATHER'S NAME First Middle Last <b>John Dameron</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>SARAH Dameron</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-12-7671</b>		17. INFORMANT <b>HATTON A DAMERON</b> Address <b>11405 Columbia Pike Silver Spring, Md.</b>							
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Vascular Collapse</b> DUE TO, OR AS A CONSEQUENCE OF <b>Diabetic Mellitus</b> 3ms Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetic Mellitus, uncontrolled</b> DUE TO, OR AS A CONSEQUENCE OF <b>Diabetic Mellitus, uncontrolled</b> (c) <b>Diabetic Mellitus, uncontrolled</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3ms</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>260x</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>1-29</b> , 19 <b>68</b> , to <b>2-9</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2-9</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Alfred K. Lefohn</b>		DEGREE <b>ALFRED K. LEFON</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/9/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>ALFRED K. LEFON</b>		22e. ADDRESS <b>CLINTON, MD</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>2/12/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WASH. NATIONAL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>SUITLAND, PRINCE GEORGES, Md.</b>					
24. FUNERAL DIRECTOR <b>Robert E. Wilkerson</b>		ADDRESS <b>4308 Suitland Rd Suitland Md</b>		25a. REC'D BY REGISTRAR <b>FEB 14 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR		
Peter Edward Dansberry						MATED <input checked="" type="checkbox"/> 2-26-68 192		55pm M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD		
Male	White	2-9-1900	68 YRS					Month 2 Day 26 Year 68 19 3:05pm M		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
NEW JERSEY		U.S.				Prince George's Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			STONE MASON				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before address, give street and number)			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Prince George		Seabrook				6410 98th. Avenue	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
UNKNOWN			UNKNOWN							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
No			579015997A		MRS FRANCES A. DANSBERRY SAME AS #13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED		
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		2-27-68		
						DEPUTY MED. CA. EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)		
BURIAL		1 MARCH 1968		FORT LINCOLN CEM		COLMAR MANOR, MARYLAND				
24 FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
W.W. CHAMBERS Co RIVERDALE, MARYLAND						DATE MAR 1 1968		J. Charles Jones		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

02990

02975

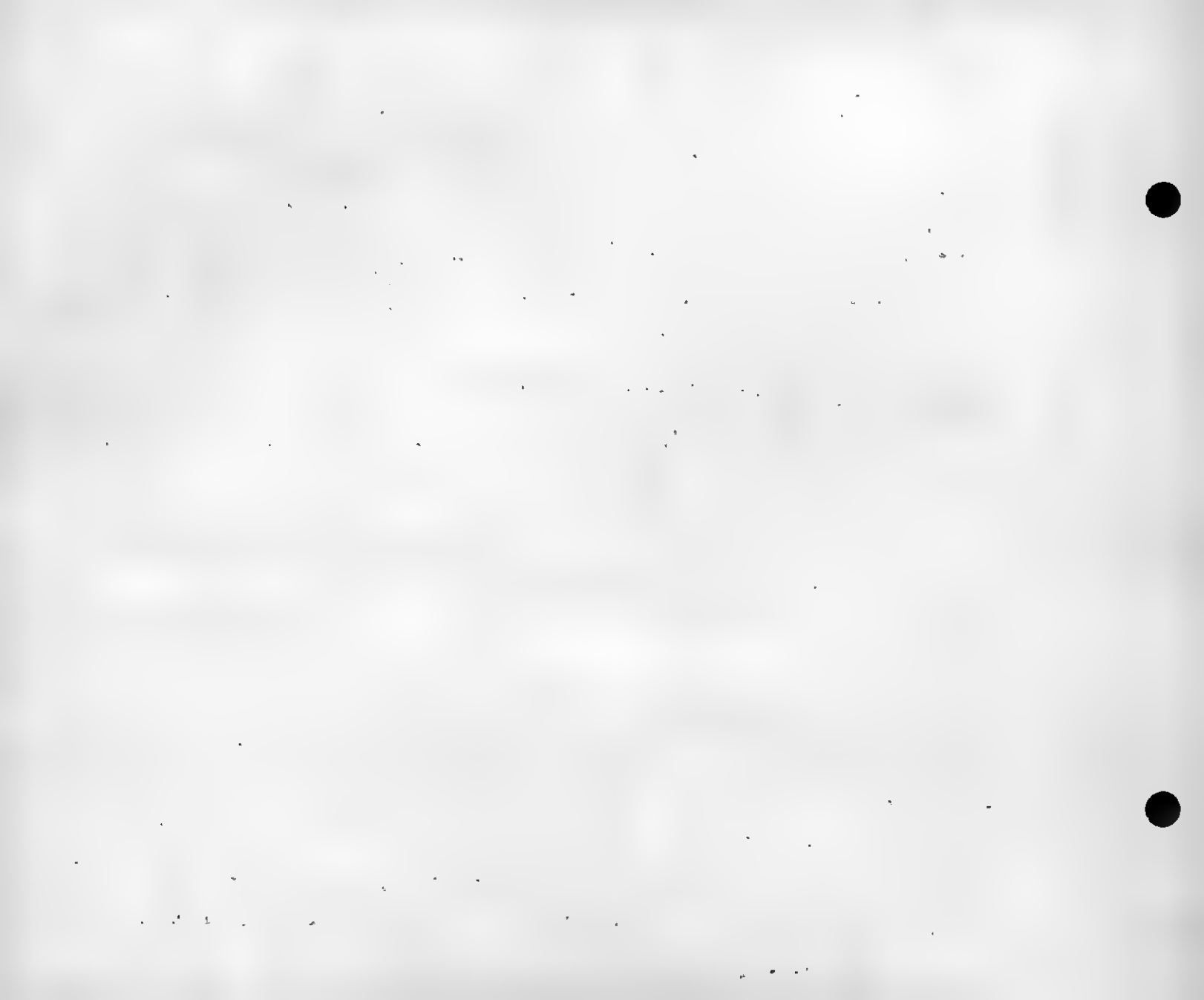
1. DECEASED NAME (Type or print) First Middle Last <b>MARY BREWER DAVIS</b>			2a. DATE OF DEATH Month Day Year 24 HOUR <b>2 29 68 11 P M</b>		
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>Oct 25-1881</b>	6. AGE (In years last birthday) <b>86</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>US</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>PRINCE GEORGES</b> Md		
10. CITY OR TOWN OF DEATH <b>HYATTSVILLE</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hyattsville Nursing Home</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>D.C.</b>	13b. COUNTY <b>C</b>	13c. CITY OR TOWN <b>Washington</b>	3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>2440 16th St.</b>	
14. FATHER'S NAME First Middle Last <b>JAMES LYNN DAVIS</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>JANE PLATER DAVIS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>579-60-0343</b>	17. INFORMANT Address <b>Nursing Home - Hyattsville, Md</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Parkinson's disease severe</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>250x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>years</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Severe malnutrition &amp; inanition - 6 months</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
22a. I certify that (I) (this hospital) attended the deceased from <b>4/20</b> , 19 <b>66</b> , to <b>2/29</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2/13</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.					
22b. SIGNATURE <b>Harold W. Draper M.D.</b>		22c. DATE SIGNED <b>2/29/68</b>	22d. PHYSICIAN'S NAME (Type) <b>HAROLD W. DRAPER M.D.</b>		
22e. ADDRESS <b>9801 GEORGIA AVE Silver Spring, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>3/7/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Monocacy</b>	23d. LOCATION (City or Town) (County) (State) <b>Beallville Mont. Md</b>		
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 7 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or print) <b>John</b>			First <b>C</b>		Middle <b>Deck Sr.</b>		Last <b>Feb</b>		2a DATE OF DEATH Month <b>9</b> Day <b>68</b> Year		2b HOUR <b>7:04</b> M	
3 SEX <b>male</b>			4 RACE <b>white</b>			5 DATE OF BIRTH <b>12-24-89</b>			6 AGE (In years last birthday) <b>78</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>			7b CITIZEN OF WHAT COUNTRY? <b>USA</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>Prince George's County</b> Md			
10 CITY OR TOWN OF DEATH <b>Greenbelt</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Greenbelt Convalescent Cent</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Linotype operator</b>			12b KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Md.</b>			13b. COUNTY <b>P.G.</b>			13c CITY OR TOWN <b>Riverdale</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>4712 Oliver St.</b>	
14. FATHER'S NAME <b>Bernard</b>			First <b>G</b>		Middle <b>Deck</b>		Last <b>Odella</b>		15. MOTHER'S MAIDEN NAME <b>Glatius</b>		Last	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) <b>no</b>			16b SOCIAL SECURITY NO <b>1908-1910</b>			17 INFORMANT <b>MRS. Robert Saylor</b>			Address <b>4518 Tuckerman St. Riverdale, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction</b>												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>1729</b>												
DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>arterio-sclerotic heart disease</b>												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State						
22a I certify that (I) (this hospital) attended the deceased from <b>Jan 17, 1967</b> , to <b>Feb 9, 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb 9, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b SIGNATURE <b>Vic Bergerman MD</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c DATE SIGNED <b>Feb 9, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>TICE BERGERMAN</b>						22e ADDRESS <b>Greenbelt Prof Building Greenbelt Md</b>						
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>2/12/68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet</b>			23d LOCATION (City or Town) (County) (State) <b>Washington D. C.</b>			
24 FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Maryland</b>						ADDRESS			25a REC'D BY REGISTRAR <b>FEB 13 1968</b>			
									25b. REGISTRAR'S SIGNATURE			



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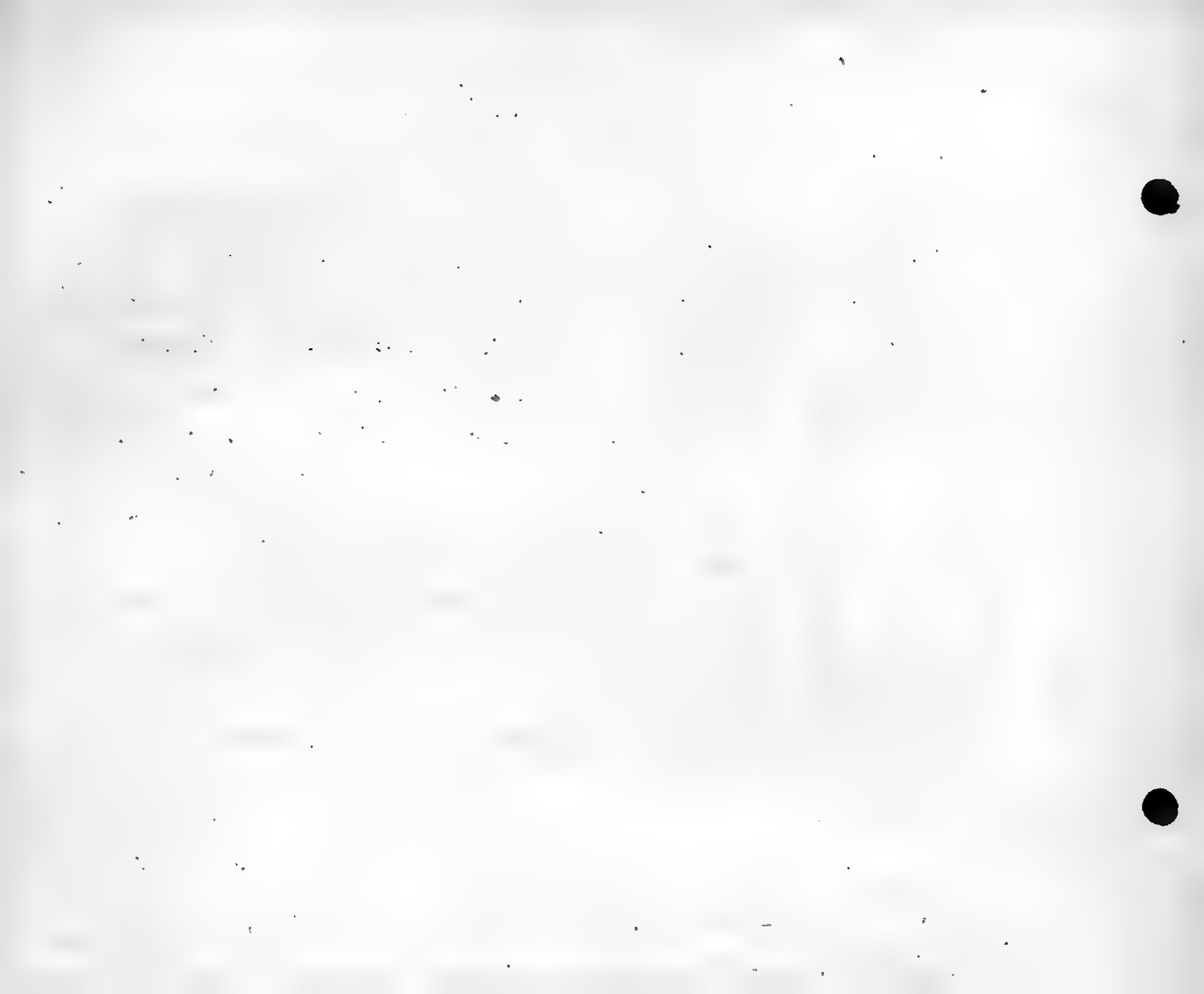
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
LUCIE			EMILIE DE LATTRE			FEB Month 25 Day 1968 Year			12 <sup>15</sup> P. M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		CAUC.		10-10-'81		86 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
SWITZERLAND		Switzerland				PR. GEORGE'S Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
LANDOVER HILLS			3734 INGALLS AVE Residence			HOMEMAKER					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN/HILL		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
MD			PR. GEO			LANDOVER		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3734 INGALLS AVE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
FRITZ FREDERICK RACLE			ELISE (EMILY) LUCIE BARDET								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17. INFORMANT Address					
NO			None			Mrs. May E. Joergensen Ave Landover Estates Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										2 DAYS	
4109 DUE TO, OR AS A CONSEQUENCE OF										ACUTE INTESTINAL OBSTRUCTION	
Cond tans, if any, which gave rise to immediate cause (a), stating the underlying cause last										2 DAYS	
(b) DUE TO, OR AS A CONSEQUENCE OF										MESENTERIC THROMBOSIS	
(c) DUE TO, OR AS A CONSEQUENCE OF										GEN. ARTERIOSCLEROSIS	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										UNKNOWN	
7! CORONARY THROMBOSIS											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 2-29-68, 1968, to PRESENT, 1968, that (I) (we) last saw the deceased alive on 2-12-68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. DR KEHOC NOTIFIED											
22b. SIGNATURE		C. J. Houmann		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
								2-25-68			
22d. PHYSICIAN'S NAME (Type)		C. J. HOUMANN M.D.		22e. ADDRESS		RIVERDALE MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
BURIAL		2-29-68		Washington National		Suitland Maryland					
24. FUNERAL DIRECTOR		U. W. Chambers		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
				4000 Chapin St		DATE		MAR 6-1968			



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) First Middle Last <i>Myrtle E. DeBozier</i>			2a. DATE OF DEATH Month Day Year <i>Feb. 25 1968</i>			2b. HOUR <i>7:15 P.M.</i>			
3. SEX <i>Female</i>		4. RACE <i>white</i>		5. DATE OF BIRTH <i>12-5-1906</i>		6. AGE (In years last birthday) <i>61 YRS.</i>		F. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince George county Md</i>			
10. CITY OR TOWN OF DEATH <i>Clinton</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Clinton Community Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOUSEWIFE</i>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>md</i>		13b. COUNTY <i>Prince George</i>		13c. CITY OR TOWN <i>Otan Hill</i>		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>2200 Tucker Rd. SE</i>	
14. FATHER'S NAME First Middle Last <i>Bruce Rawlings</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>CORA Curtin</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT <i>Marcellus DeBozier</i> Address <i>2200 Tucker Rd SE</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>MYOCARDIAL INFARCTION</i> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <i>GENERALIZED ATROSC.</i> > 1 YR. DUE TO, OR AS A CONSEQUENCE OF (c) <i>DUCED ENAL ULCER</i> > 1 MO.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>15 Feb</i> , 19 <i>68</i> , to <i>25 Feb</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>25 Feb</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Robert W. Merkle</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <i>Feb 25, 68</i>				
22d. PHYSICIAN'S NAME (Type) <i>ROBERT W. MERKLE</i>					22e. ADDRESS <i>116 McKendree Rd. Brandywine, md</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>2-29-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. John's Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Clinton, Maryland</i>			
24a. FUNERAL DIRECTOR <i>Simmons Bros</i>		ADDRESS <i>1661 Good Hope Rd SE Wash</i>		DC		25a. REC'D BY REGISTRAR <i>FEB 27 1968</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	





02994

# CERTIFICATE OF DEATH

02979

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Prince George</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Bolivia</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>8 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1816 Metzger Road</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Teresa</u> Middle <u>LOA</u> Last <u>De Pondo</u>		4. DATE OF DEATH Month <u>February</u> Day <u>4</u> Year <u>1968</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 12, 1926</u>
9. AGE (In years last birthday) <u>41</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		12. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
13. BIRTHPLACE (State or foreign country) <u>Bolivia</u>		14. CITIZEN OF WHAT COUNTRY? <u>Bolivia</u>	
15. FATHER'S NAME <u>Pacifico Abariega</u>		16. MOTHER'S MAIDEN NAME <u>Dominga Fortan</u>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		18. SOCIAL SECURITY NO. <u>—</u>	
19. INFORMANT <u>Aguilar, Guzman</u>		Address <u>1816 Metzger Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4129 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 4129 (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb 4, 1968</u> to <u>Feb 4, 1968</u> , that I last saw the deceased alive on <u>Feb 4, 1968</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Sydney Leventhal, M.D.</u>		DATE SIGNED <u>Feb 4, 1968</u>	
PHYSICIAN'S NAME (Type) <u>Sydney Leventhal, M.D.</u>		<u>Silver Spring, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	22b. DATE THEREOF <u>2/4/68</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph Gawler's Sons Inc.</u>		ADDRESS <u>Washington, D.C.</u>	
24a. REC'D BY REGISTRAR <u>FEB 8 1968</u>		24b. REGISTRAR'S SIGNATURE <u>—</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. OR: After this certificate has been signed by the attending physician and completely filled out, it should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

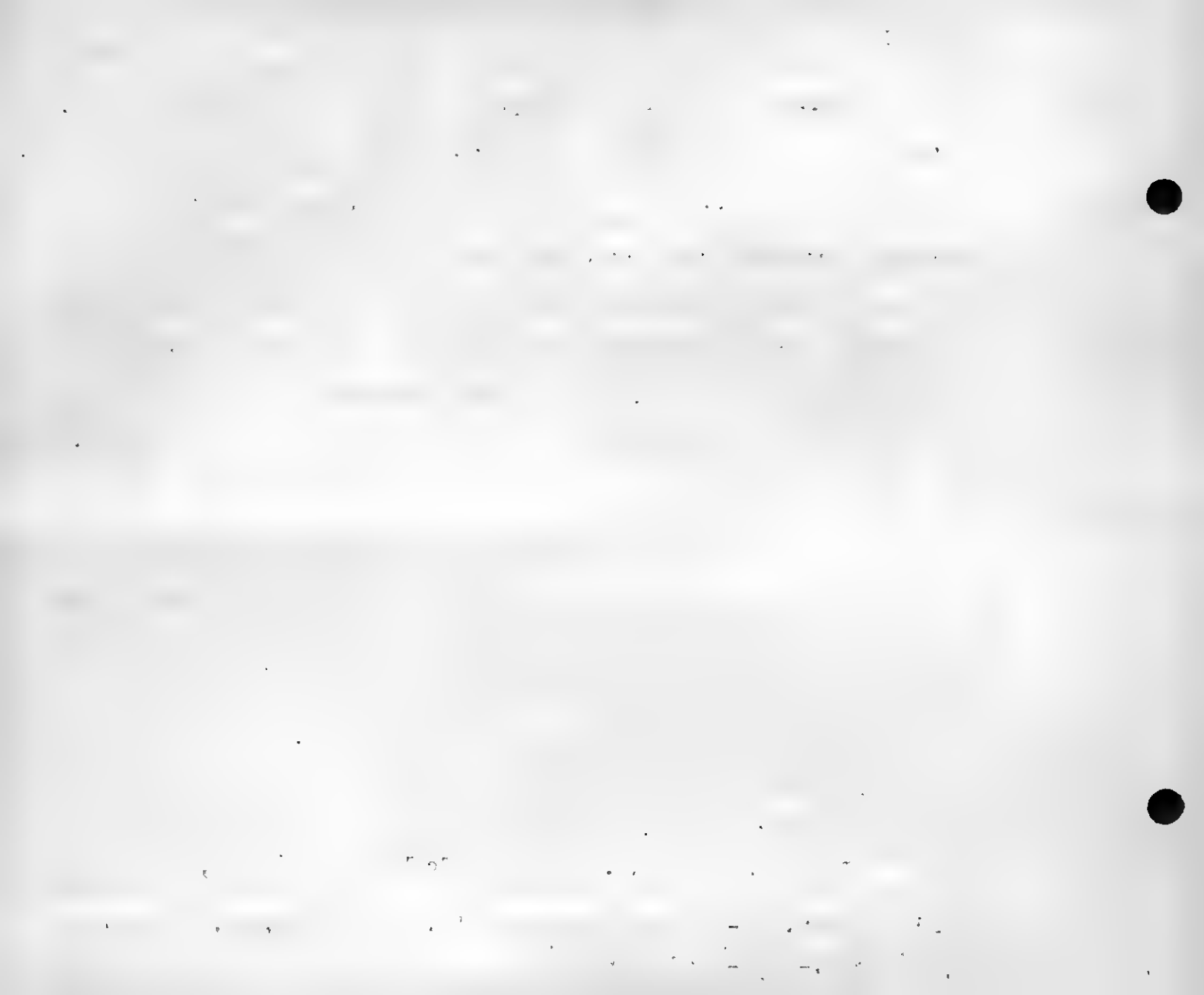
Completed by John Kefauver, M.D. Dep. Medical Officer



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last <b>Infant Boy DePRINCE</b>						2a. DATE OF DEATH Month Day Year <b>Feb 9 1968</b>			2b. HOUR <b>11:30 PM</b>		
3 SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Feb. 9, 1968</b>			6. AGE (In years lost birthday) YRS. MONTHS DAYS <b>5 5 40</b>				
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George's</b> Md.				
10. CITY OR TOWN OF DEATH <b>Andrews Air Force Base</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Malcolm Grow USAF Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>N/A</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
13a. USUAL RESIDENCE (Where deceased lived if not institution. Residence before admission) STATE <b>N/A</b>		13b. COUNTY <b>N/A</b>		13c. CITY OR TOWN <b>N/A</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>N/A</b>			
14. FATHER'S NAME First Middle Last <b>Michael Anthony DePrince</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Pauline Rita Marcoux</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO <b>N/A</b>		17. INFORMANT <b>Mother (see item 15)</b>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>777X IMMEDIATE CAUSE (a) Immaturity</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 hr. 40 min.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (This hospital) attended the deceased from <b>4 FEB 1968</b> , to <b>4 FEB 1968</b> , that (I) (we) last saw the deceased alive on <b>4 FEB 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William E. Palma</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <b>9 FEB 68</b>					
22d. PHYSICIAN'S NAME (Type) <b>WILLIAM E. PALMA, M.D.</b>						22e. ADDRESS <b>Malcolm Grow USAF Hosp, AAFB, Wash, DC</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb. 13-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l.</b>			23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>				
24. FUNERAL DIRECTOR <b>Simmons Bros.</b> ADDRESS <b>Wash DC</b>						25a. REC'D BY REGISTRAR DATE <b>FEB 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

82096

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

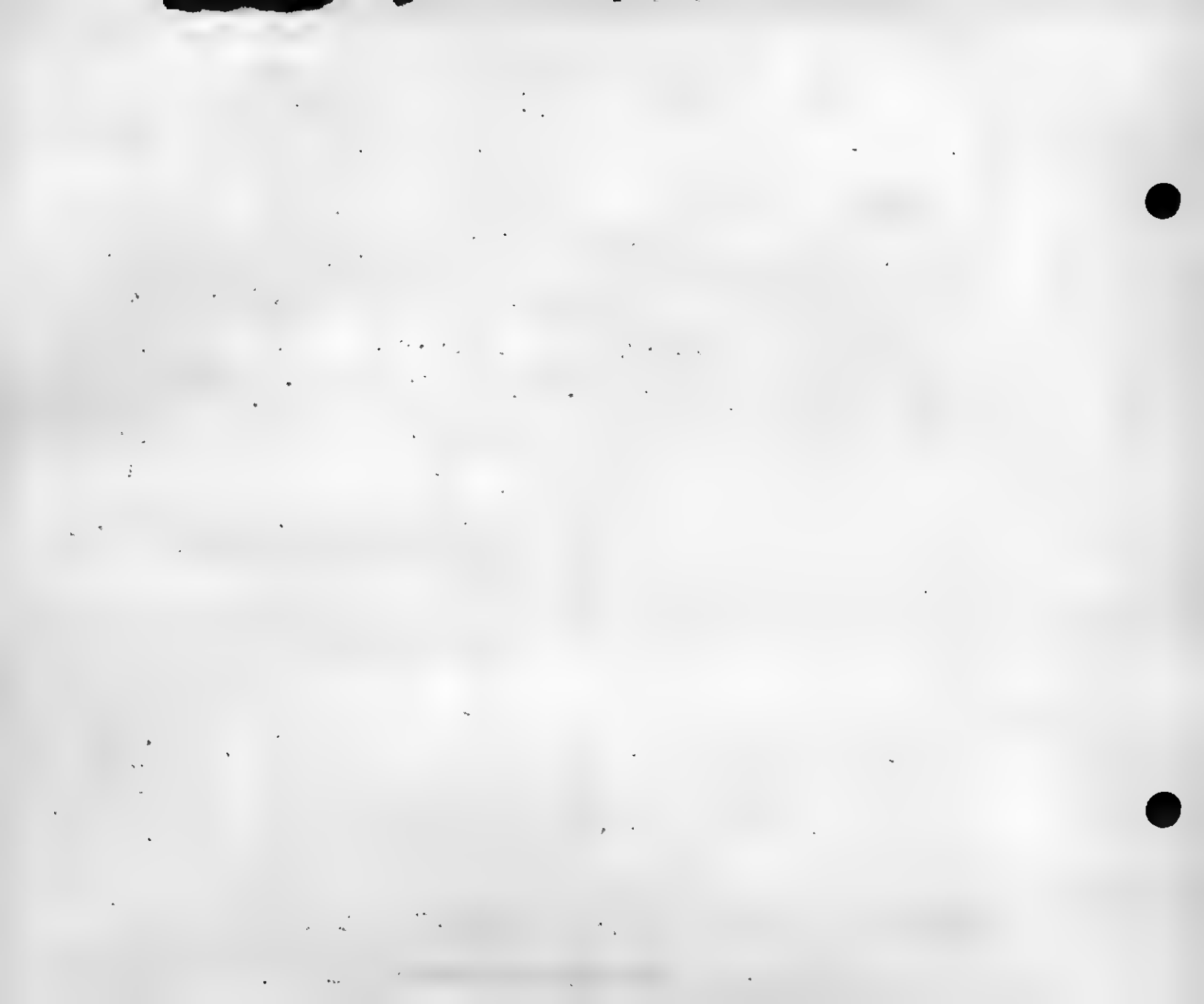
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year MATED <input type="checkbox"/> 2-25-68 194:50amM			2b HOUR		
James Nathaniel DeVaughn											
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male		Negro		9-26-1926		41 YRS					
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
Florence S C				U.S.A.				9. COUNTY OF DEATH Prince George's Md			
10 CITY OR TOWN OF DEATH				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			
Cheverly				Prince George Hospital				Laborer			
13a USUA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE				13b COUNTY				13c CITY OR TOWN			
District of Columbia				Washington				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last				13e. STREET AND NUMBER			
Armous DeVaughn				Martha Abron				1510 Olive Street N.E.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
None				No				Willie M DeVaughn-1510 Olive St. NE- Wife			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Epidural hematoma, massive, right										2 days	
DUE TO, OR AS A CONSEQUENCE OF Skull fracture										2 days	
Conditions, if only, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) From Trauma											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4035											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				7:00am 2-23-1968				Fell and struck head on pavement.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
				In front of Franks Tavern, 1703 Kenilworth Ave, Beaver Heights, Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				M.D.				22b. DATE SIGNED			
EXAMINER'S NAME (Type)								2-26-68			
John Kehoe MD				Riverdale, Md.				ADDRESS (Street city town, or county)			
23a BURIAL (CREMATION, REMOVAL) (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
Burial		3-2-68		Lincoln Memorial				Suitland, Maryland			
24. FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR DATE			
John T. Rhines Co. Funeral Home				3015 12th Street, N.E. Washington, D. C.				MAR 4 1968			
								25b REGISTRAR'S SIGNATURE			
								Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR		
Adeline L. Dixon						FEB. Month 29 Day 1968 Year			4 P.M.		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		F UNDER 1 YEAR MONTHS		F UNDER 24 HRS HOURS MIN	
FEMALE		Caucasian		MARCH 15 1886		51 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
MINN.		U.S.A.				PRINCE GEORGES Md					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
FORESTVILLE			RECENT NURSING HOME 4300 Marlboro Pike			HOUSEWIFE POSTOFFICE CLERK			POST OFFICE		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
WASH. D.C.			V		WASH. DC		YES		2816 Q ST. S.E.		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last								
Louis			INGEBRETSON			UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war and dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address						
No			579 482762A		Wilfred S. Dixon Sec 13C E						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
+ 124 Congestive Heart Failure											1 wk.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost +											4 yrs.
(b) DUE TO, OR AS A CONSEQUENCE OF											
Diffuse U.S.											10 yrs.
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
Burns 20-30 burns treated											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
						1954			2/29/68		
22a. I certify that (I) (this hospital) attended the deceased from 1954, 19 to 2/29, 1968, that (I) (we) lost saw the deceased alive on 2/29, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED		
W. W. Chambers									2/29/68		
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Cremation			Mar. 4 1968		Ft. Lincoln Crematory			Bladensburg Md			
24. FUNERAL DIRECTOR			ADDRESS			25a. RECEIVED BY REGISTRAR DATE			25b. REGISTRAR'S SIGNATURE		
W. W. Chambers			1400 Chapin St. NW Wash. D.C.			MAR 5 1968			Charles J. Jones		





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
Lawrence L. Dorsey						Month Day Year 2 3 1968			1:03 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD	
male	Negro	11-29-39	28 YRS					Month Day Year 2 3 1968	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
D. C.		U. S. A.				Prince George's Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. LSUA. OCCUPATION (Kind of work done during most of work ng life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince George's Gen. Hosp.			METROPOLITAN POLICEMAN			
13a. LSUA. RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS		13e. STREET AND NUMBER	
-			-		Wash. D.C.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1500 19th Street, S.E.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last LAWRENCE DORSEY, SR.			First Middle Last DOLORES HALL						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT				
YES					ROSETTA DORSEY - 1500-19th Street, S. E.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.									
(b) <u>Generalized peritonitis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>shot gun wound of abdomen</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
784x									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?			
1-27-68			gun shot wound of abdomen			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year HOUR A.M. 2:30 P.M. 1-27 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
					shot during altercation				
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory office building etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
		front of building at		380 Eastern Avenue, N.E.		Washington D.C.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		2-1-68	
John Kehoe M.D., Riverdale, Maryland						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			2-7-68		Lincoln Memorial		Suitland, Maryland		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
John T. Rhines Company Funeral Home 3015 12th Street, N. E.					DATE FEB 8 1968				

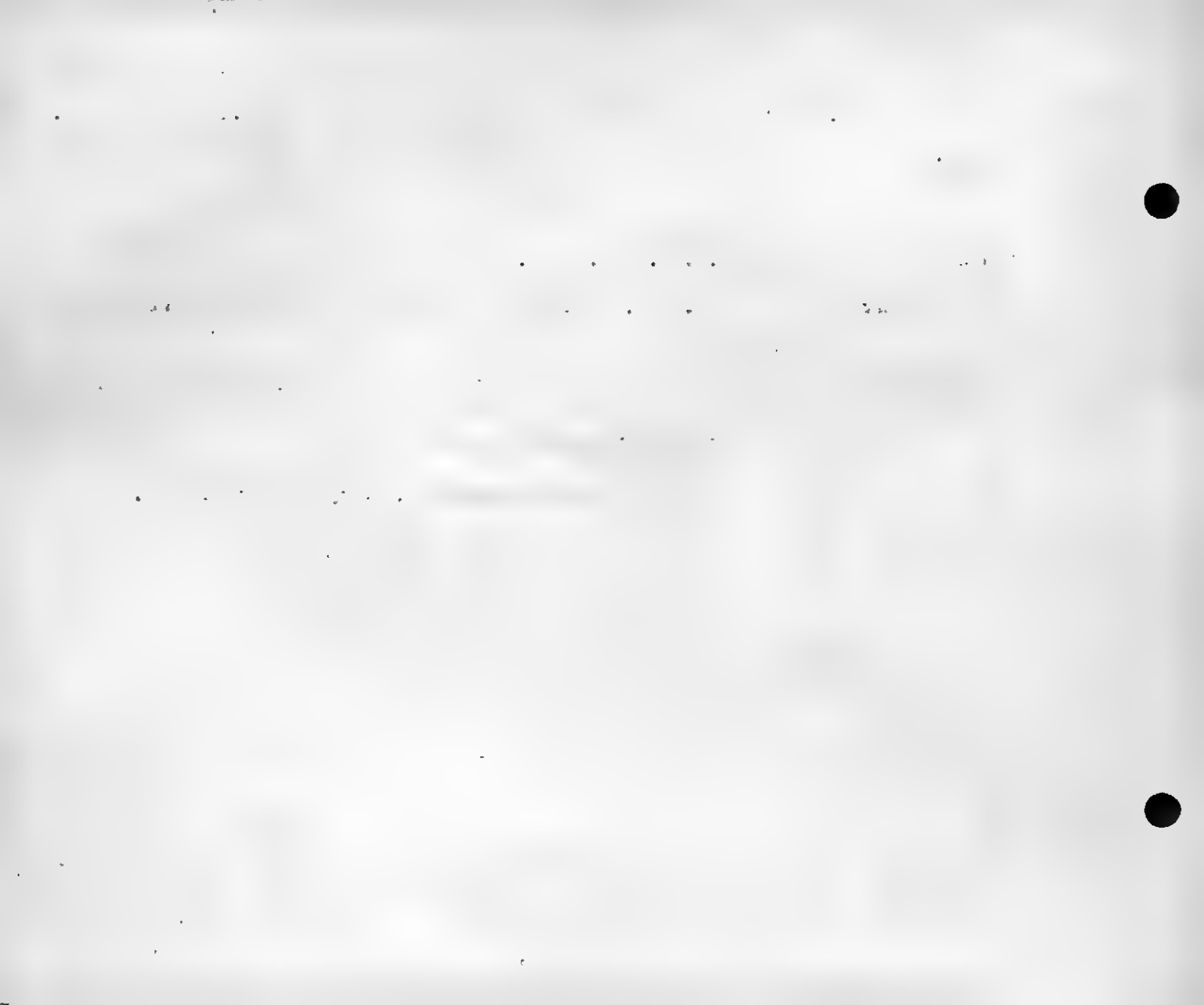


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Stella A Downs</b>			2a. DATE OF DEATH Month <b>Feb.</b> Day <b>5</b> Year <b>68</b>		2b. HOUR <b>6.00AM</b>
3. SEX <b>Female</b>		4. RACE <b>White</b>	5. DATE OF BIRTH <b>18 July 1880</b>		6. AGE (In years last birthday) <b>87</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pr. Geo. Gen. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b></b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Pr. Geo.</b>	13c. CITY OR TOWN <b>Cheverly</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>David Edwards</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>?</b>		13e. STREET AND NUMBER <b>6103 Montrose Road</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>H Max Thompson</b> Address <b>Cheverly, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ruptured abdominal aneurysm</b> <b>+41.2</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic occlusion, left coronary artery.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>451x</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>
19a. DATE OF OPERATION <b></b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b></b>		21b. TIME OF INJURY HOUR A.M. Month Day Year <b></b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b></b>	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b></b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b></b>	
22a. I certify that (I) (this hospital) attended the deceased from <b>1/23, 1968</b> , to <b>2/5, 1968</b> , that (I) (we) last saw the deceased alive on <b>2/4, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b></b>		22c. DATE SIGNED <b>2/5/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>F. E. Musser, M.D.</b>		22e. ADDRESS <b>4410-74th Ave Hyattsville, Md.</b>		22f. ADDRESS <b>Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL, (Specify) <b>Burial</b>		23b. DATE <b>Feb 8, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ridgeville Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Ridgeville Randolph Indiana</b>		24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		25a. REC'D BY REGISTRAR <b>FEB 8 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					



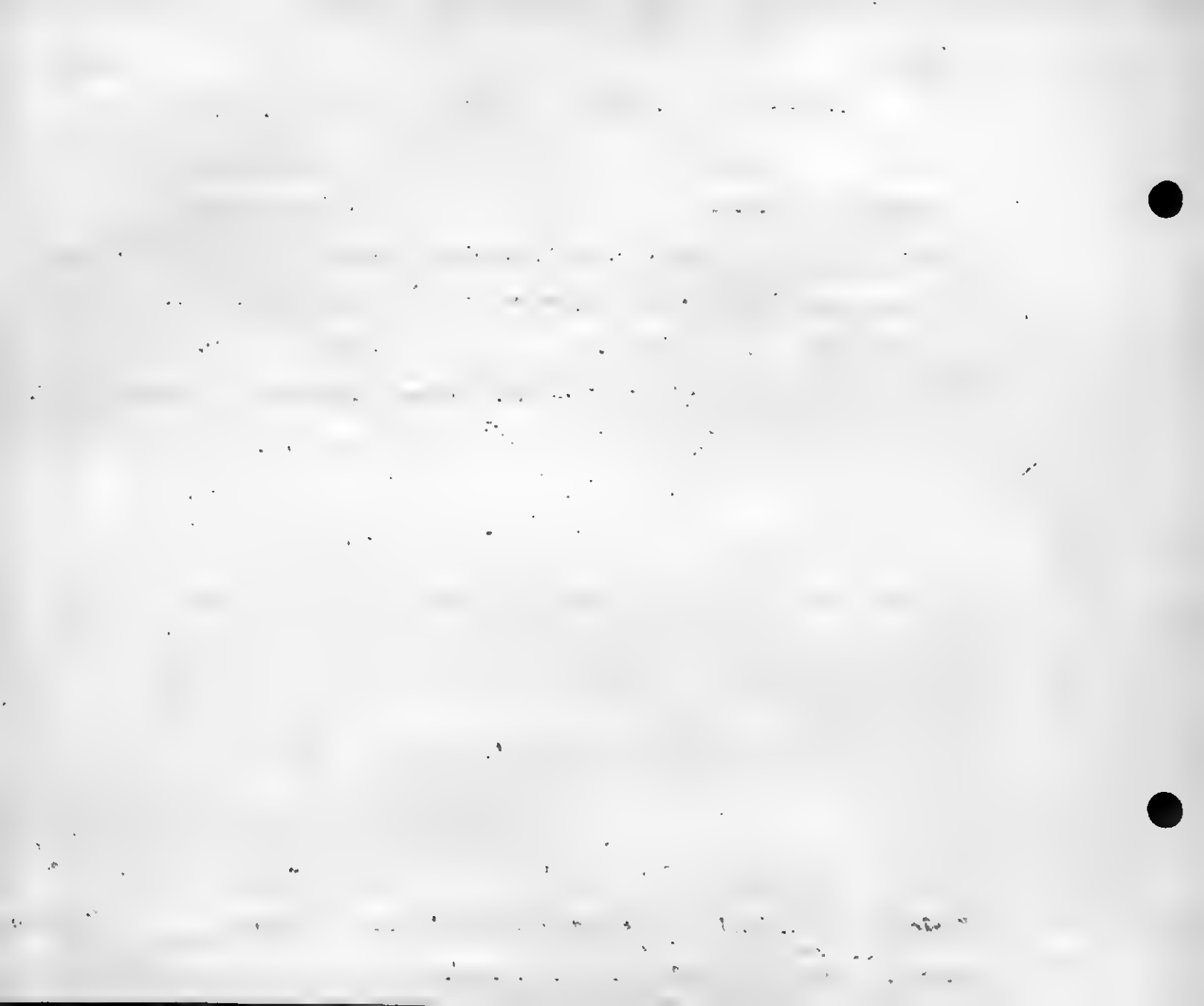
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Dr. Robert M. Notified and Approved

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First Middle Last <b>Margaret Crown Dugan</b>			2a. DATE OF DEATH Month Day Year <b>Feb. 21, 1968</b>		2b. HOUR <b>6:15 PM</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>7-25-84</b>		6 AGE (In years lost birthday) <b>83</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <b>Prince George's</b> Md		
10 CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>own home</b>
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b COUNTY <b>Prince George's</b>	13c CITY OR TOWN <b>Hyattsville</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>7200 Md. Blvd.</b>	
14 FATHER'S NAME First Middle Last <b>William J. Willix</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Henrietta O. Gordon</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) <b>219-54-9846</b>		17 INFORMANT Address <b>Mrs. Florence D. Foley 7200 Maryland Blvd.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Massive cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic Cardio-vascular dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>with 3rd degree AV block</b>					APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>2/21</b> , 19 <b>68</b> , to <b>2/21</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>2/21</b> 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>R. FRANCHI</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>2-22-68</b>	
22d PHYSICIAN'S NAME (Type) <b>R. FRANCHI, MD</b>		22e. ADDRESS <b>7729 Finns Lane Landrum Md</b>			
23a. BURIAL, CREMATON, REMOVAL (Specify) <b>Burial</b>	23b DATE <b>Feb. 26, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cgr.</b>		23d LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>C. Glen Carter</b>		ADDRESS <b>Warner E. Pumphrey Inc. 8434 Ga. Ave. S.E., Md.</b>		25a. REC'D BY REGISTRAR <b>Feb 27 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
DECEASED NAME (Type or Print) First Middle Last (Nancy) Nanne Rose Dunbar						2a. DATE KNOWN OF EST DEATH MATED <input checked="" type="checkbox"/> 2 16 1968 2:00 PM		2b. HOUR			
3 SEX Female		4 RACE White		5 DATE OF BIRTH 3-19-19		6. AGE (In years last birthday) 48 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Oxon Hill, Md.				7b. CIT. ZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George County, Md.		2c. DATE PRONOUNCED DEAD February 16 1968 5:53 PM	
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Gen. Hosp.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret red) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.				13b. COUNTY Prince George		13c. CITY OR TOWN Oxon Hill		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1532 Clayton Drive	
14. FATHER'S NAME First Middle Last John Callahan				15. MOTHER'S MAIDEN NAME First Middle Last Lo Ellen Griffith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO.		17. INFORMANT Jesse R. Dunbar (Husband)				ADDRESS Same as # 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Death by Strangulation due to hanging</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 974X											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Cornelius J. Burns</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED Feb. 17, 1968			
EXAMINER'S NAME (Type) Cornelius J. Burns, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				ADDRESS (Street, city, town, or county) Cheverly, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Feb. 21, 68		23c. NAME OF CEMETERY OR CREMATORY Callahan & Griffith Cemetery, Houston, Ky.				23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Simmons Bros. 1661-Gd. Hope Rd. SE. Wash. DC.						25a. REC'D BY REGISTRAR FEB 20 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
CERTIFICATE OF DEATH														
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR					
Henry E. Ebel						Feb. 9, 1968			12 Noon					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR		8. UNDER 24 HRS			
Male		Caucasian		9/14/95			72 YRS.		MONTHS		DAYS			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH			Md.		
NEW JERSEY			U.S.						Prince Georges					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly			Prince Geo. Gen'l Hospital			Window trimmer								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Maryland			Prince Georges			Dist. Hgts			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			6626 Ronald Road		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last											
UNKNOWN EBEL			BARBARA UNKNOWN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address					
YES			1917-1919			UNKNOWN			MRS. EVELYN R. EBEL			13a E. C. Ave above		
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> <u>150X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Carcinoma of esophagus with metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastasis to neck, left lung, liver, Lt femur, etc</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>(1) Hypostatic pneumonia (2) Myocardial ischemia</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>Jan. 21</u> , 19 <u>68</u> , to <u>Feb. 9</u> , 19 <u>68</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>Feb. 9</u> , 19 <u>68</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.														
22b. SIGNATURE			22c. DATE SIGNED			22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS					
<u>Riccardo Franchi, M.D.</u>			2-10-68			Riccardo Franchi, M.D.			Prince Georges General Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
BURIAL			13 FEB 1968			WASHINGTON NATIONAL			SUITLAND MD.					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
RINALDI FUNERAL HOME, INC.			7400 GEORGIA AVE. N.W. DC 20012			DATE FEB 13 1968								



CERTIFICATE OF DEATH

1550

03003

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Medical Examiner's Note

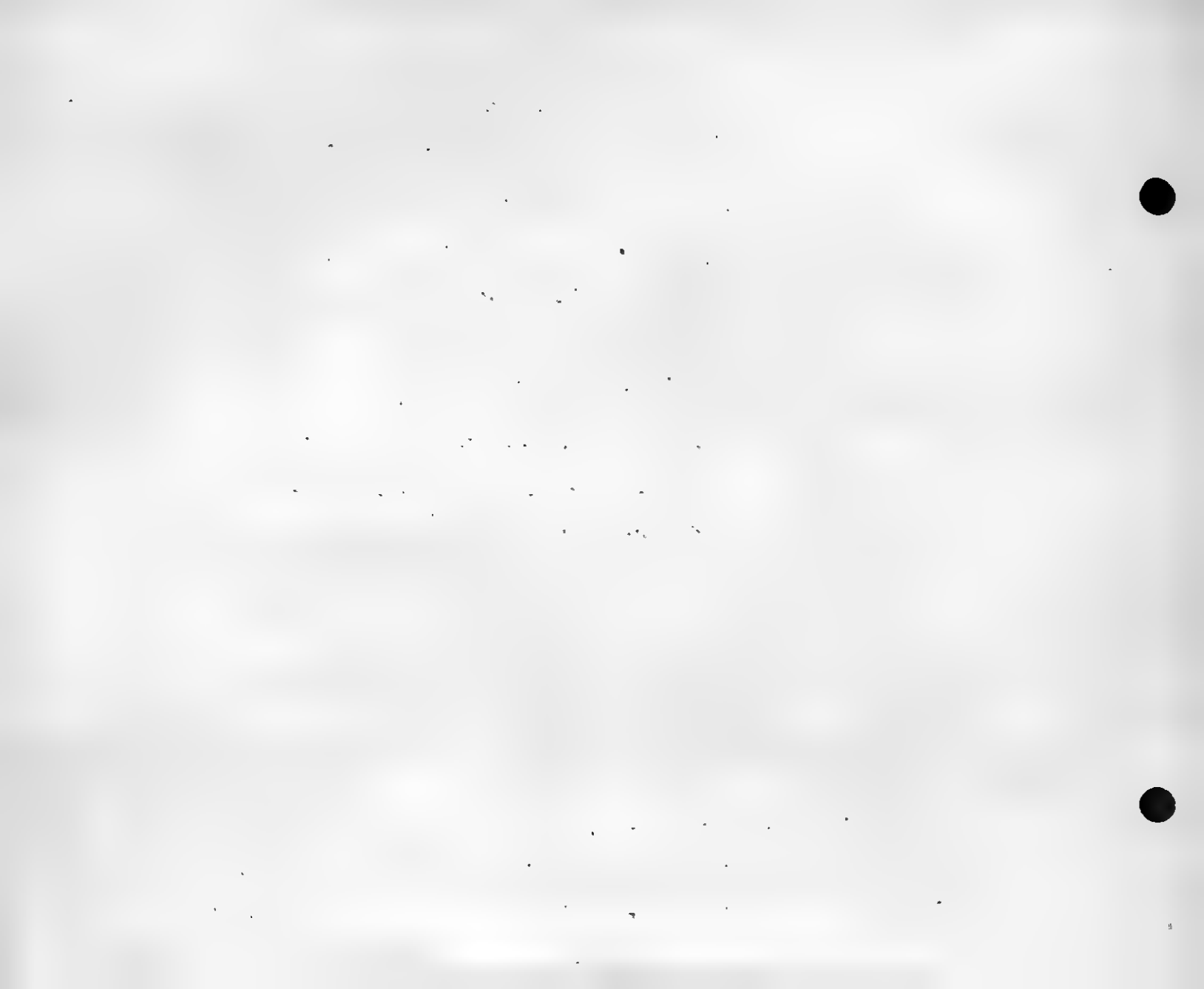
1 PLACE OF DEATH a. COUNTY <u>PRINCE GEORGES</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institut on Residence before adm:ss on) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>				c LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1404 KANAWHA STREET</u>				d STREET ADDRESS <u>1404 KANAWHA STREET</u>			
3 NAME OF DECEASED (Type or print) First Middle Last <u>ARTHUR</u> <u>ERICKSON</u>				4 DATE OF DEATH Month Day Year <u>FEB</u> <u>20</u> <u>1968</u>			
5 SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>9/20/20</u>	
9 AGE (In years lost birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MAIL CARRIER</u>				10b KIND OF BUSINESS OR INDUSTRY <u>POST OFFICE</u>		11 BIRTHPLACE (County & State, or foreign country) <u>NEW YORK</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>ARTHUR P. ERICKSON</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET ECKES</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>1942-45</u>				16 SOCIAL SECURITY NO		17 INFORMANT <u>KENNETH M. ERICKSON</u> <u>PARENT</u> <u>62 DUDLEY DR BIRKENHEAD</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4107</u> <u>CORONARY OCCLUSION</u> DUE TO (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>3 YEARS</u>			
PART II OTHER SIGNIFIKANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OBESITY</u> <u>PERIPHERAL ATHEROSCLEROSIS</u>				19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from <u>2/10</u> , 19 <u>66</u> , to <u>2/20</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2/20</u> 19 <u>68</u> , and that death occurred at <u>6:40 PM</u> , from causes and on the date stated above.							
22a SIGNATURE <u>James A. Roberts</u> M.D.				ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <u>2/20/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u>				22d ADDRESS <u>8907 GEO. AVE. SILVER SPRING, MD.</u>			
23a BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>Feb. 24, 1968</u>		23c NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Colman Manor Pk Sea Md</u>	
24 FUNERAL DIRECTOR <u>Arthur H. Roberts</u>				25a REC'D BY REGISTRAR <u>Charles Judge</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print) <b>LIBBY</b>			First Middle Last <b>ERSHAFSKY</b>			2a DATE OF DEATH <b>2</b> Month <b>21</b> Day <b>68</b> Year		2b HOUR <b>6:08 PM</b>	
3 SEX <b>F</b>		4 RACE <b>W</b>		5 DATE OF BIRTH <b>12-25-88</b>		6 AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGE</b> Md			
10. CITY OR TOWN OF DEATH <b>CLINTON MD</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>PINEVIEW GARDENS</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>MD</b>		13b. COUNTY <b>PRINCE GEORGE</b>		13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)			16b SOCIAL SECURITY NO <b>91-22-6102A</b>		17 INFORMANT <b>Mrs. Betty Levin</b> Address <b>FAULKNER, MD</b>				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> <b>1109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>Arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>6 mos.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1201</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or RFD No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>2-12-1968</b> to <b>2-21-1968</b> , that (I) (we) last saw the deceased alive on <b>2-21-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Alfred R. Larn, MD</b> DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>2-21-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>ALFRED R. LARN, MD</b>				22e ADDRESS <b>CLINTON, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>2-23-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Alt. Lebanon</b>		23d LOCATION (City or Town) (County) (State) <b>Collingdale, PA</b>			
24 FUNERAL DIRECTOR <b>B. DENZANSKY &amp; SONS-3501 14th St. N.W.</b>				25a. REC'D BY REGISTRAR <b>FEB 23 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

1968

08005

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D.C. b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 1 yr. 10 mos.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 1621 Bay Street, S.E.	
3 NAME OF DECEASED (Type or print) First Middle Last Edward Farrell		4. DATE OF DEATH Month Day Year February 26 1968	
5 SEX Male	6 COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/31/1911
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Handyman		10b. KIND OF BUSINESS OR INDUSTRY Salvation Army	
11 BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12 CITIZEN OF WHAT COUNTRY? USA	
13 FATHER'S NAME Edward Farrell		14 MOTHER'S MAIDEN NAME Mary Salmon	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> No		16 SOCIAL SECURITY NO 579-2/-0009	
17 INFORMANT (Decedent)		Address	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis 0119 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 22 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/22, 1966, to 2/26, 1968, that (H) (we) last saw the deceased alive on 2/26 1968, and that death occurred at 9:25 AM, from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 2/26/68	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Type)	23b. DATE THEREOF 3/1/68	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet	23d. LOCATION (City or town) (County) (State) Washington, D.C.
24. FUNERAL DIRECTOR Matthew 131-11th St. S.E. D.C.		25a. REC'D BY REGISTRAR DATE MAR 1 1968	
		25b. REGISTRAR'S SIGNATURE Charles Judge	





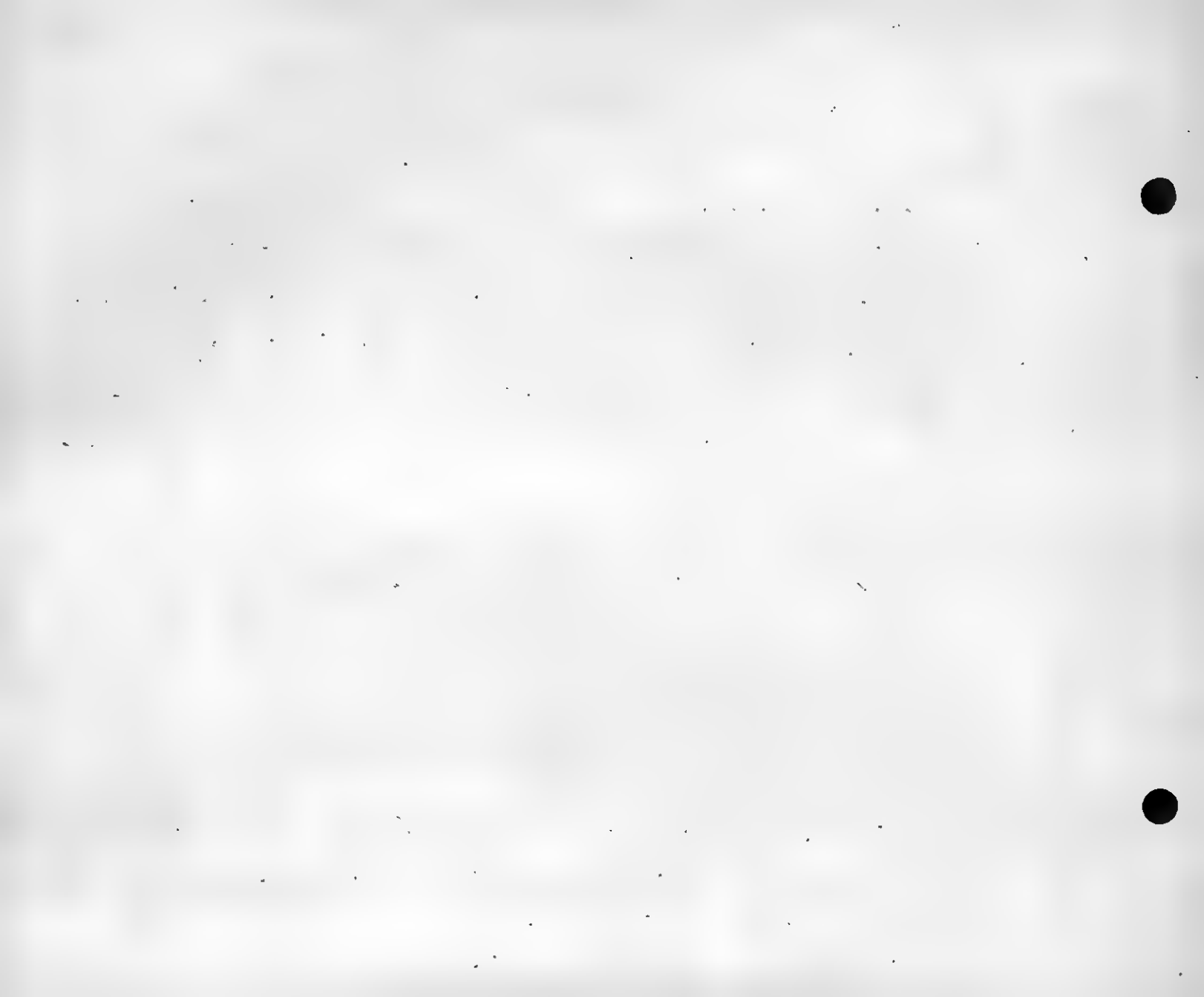
## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>Mary Frances Ferguson</b>			2a. DATE OF DEATH Month <b>2</b> Day <b>4</b> Year <b>68</b>			2b. HOUR M <b></b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>Feb. 17, 1893</b>		6 AGE (In years last birthday) <b>74</b> YRS.		IF UNDER YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>		
7a. BIRTHPLACE (State or foreign country) <b>D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.				
10 CITY OR TOWN OF DEATH <b>Hyattsville</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hyattsville Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b>			13b. COUNTY <b>Washington</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1515 R.I. Ave N.E.</b>			
14. FATHER'S NAME First Middle Lost <b>John L. Bateman</b>			15. MOTHER'S MAIDEN NAME First Middle Lost <b>Martha Brashear</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Raymond L. Ferguson Same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>486x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>486x</b> (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) <b>Chronic Brain Syndrome due to cerebral arteriosclerosis</b>										
19a. DATE OF OPERATION <b></b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b></b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b></b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b></b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b></b>						
22a. I certify that (I) (this hospital) attended the deceased from <b>1-27</b> , 19 <b>68</b> , to <b>2-4</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2-3</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Harold F. McCann</b> DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <b>Feb. 5, 1968</b>						
22d. PHYSICIAN'S NAME (Type) <b>Harold F. McCann</b>				22e. ADDRESS <b>3355 16th St. N.W. Wash. D.C.</b>						
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-7-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>				
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>				ADDRESS <b>Washington, D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John A. [Signature]</b>		

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Howard			THORNTON Feuty			Month 2 Day 4 Year 68		1255 PM		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Male		White		4/3/09		58 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
W. Va.		USA				Prince George's Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale			Leland Memorial Hos			US Gov.		Management		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			PG		Laurel		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		312 Laurel Avenue	
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
John Howard Feuty			Margaret Bryan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO		17 INFORMANT		Address			
No			123 67-0773		Mrs. Mary Feuty		Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>										
DUE TO, OR AS A CONSEQUENCE OF <u>Bronchogenic Carcinoma</u>										
DUE TO, OR AS A CONSEQUENCE OF <u>Atherosclerosis</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 4</u> , 19 <u>68</u> , to <u>Feb 4</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb 4</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Robert C. Winfield, M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					22c. DATE SIGNED <u>Feb 4 1968</u>					
22d. PHYSICIAN'S NAME (Type) <u>ROBERT C. WINFIELD</u>					22e. ADDRESS <u>Laurel Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<u>Laurel</u>		<u>2-7-68</u>		<u>Prinny Chapel Cemetery</u>		<u>Laurel Md</u>				
24 FUNERAL DIRECTOR <u>Laurel it Leonardson Laurel Md</u> ADDRESS					25a. REC'D BY REGISTRAR <u>Feb 13 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Catherine A. Finkle</b>			2a. DATE OF DEATH Month <b>2</b> - Day <b>17</b> - Year <b>1968</b>			2b. HOUR <b>10:30 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>12-1-04</b>		6. AGE (In years last birthday) <b>63</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Iowa</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.	
10. CITY OR TOWN OF DEATH <b>Clinton</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Clinton Community</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>N. Forestville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>7817 Mason St.</b>							
14. FATHER'S NAME First <b>Unknown</b> Middle <b></b> Last <b></b>				15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>Jurjens</b> Last <b></b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b></b>		17. INFORMANT <b>Floyde E. Finkle</b> Address <b>Same As # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>471X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>FLU WITH PNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>&gt; 1 Hour</b> <b>2 DAYS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>L</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Mat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>FEB 17, 1968</b> , to <b>FEB 17, 1968</b> , that (I) (we) last saw the deceased alive on <b>FEB 17, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Robert W. Merkle</b> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>				22c. DATE SIGNED <b>2-17-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Robert W. Merkle</b>				22e. ADDRESS <b>Clinton Comm Hosp, Clinton, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/20/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Epiphany Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Forestville, P.G., Maryland</b>	
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>				25a. REC'D BY REGISTRAR <b>FEB 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Jones</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1-103. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

1968

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First Middle Last Bernam G Flynt						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month Day Year <input checked="" type="checkbox"/> 2-19-68 19 4:15pm			2b. HOUR		
3. SEX Male		4. RACE White		5. DATE OF BIRTH 8-7-1906		6. AGE (In years last birthday) 61 YRS		7. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year 2 19 68 19 4:50pm	
7a. BIRTHPLACE (State or foreign country) North Carolina			7b. CITIZEN OF WHAT COUNTRY? U S A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md.		
10. CITY OR TOWN OF DEATH Cheverly				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) Painter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland				13b. COUNTY Prince George		13c. CITY OR TOWN Lanham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 7708 Prospect Avenue	
14. FATHER'S NAME First Middle Last Charles E Flynt						15. MOTHER'S MAIDEN NAME First Middle Last Nancy Celesh					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 1923-1924		17. INFORMANT Richard V. Flynt			ADDRESS Kentland, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Calcific aortic stenosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 6 mo.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building, etc.)				21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED 2-20-68			
23a. BURIAL CREMATION REMOVAL (Specify) Burial			23b. DATE Feb 23, 1968		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery			23d. LOCATION (City or Town) (County) (State) Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR DATE FEB 26 1968		25b. REGISTRAR'S SIGNATURE			





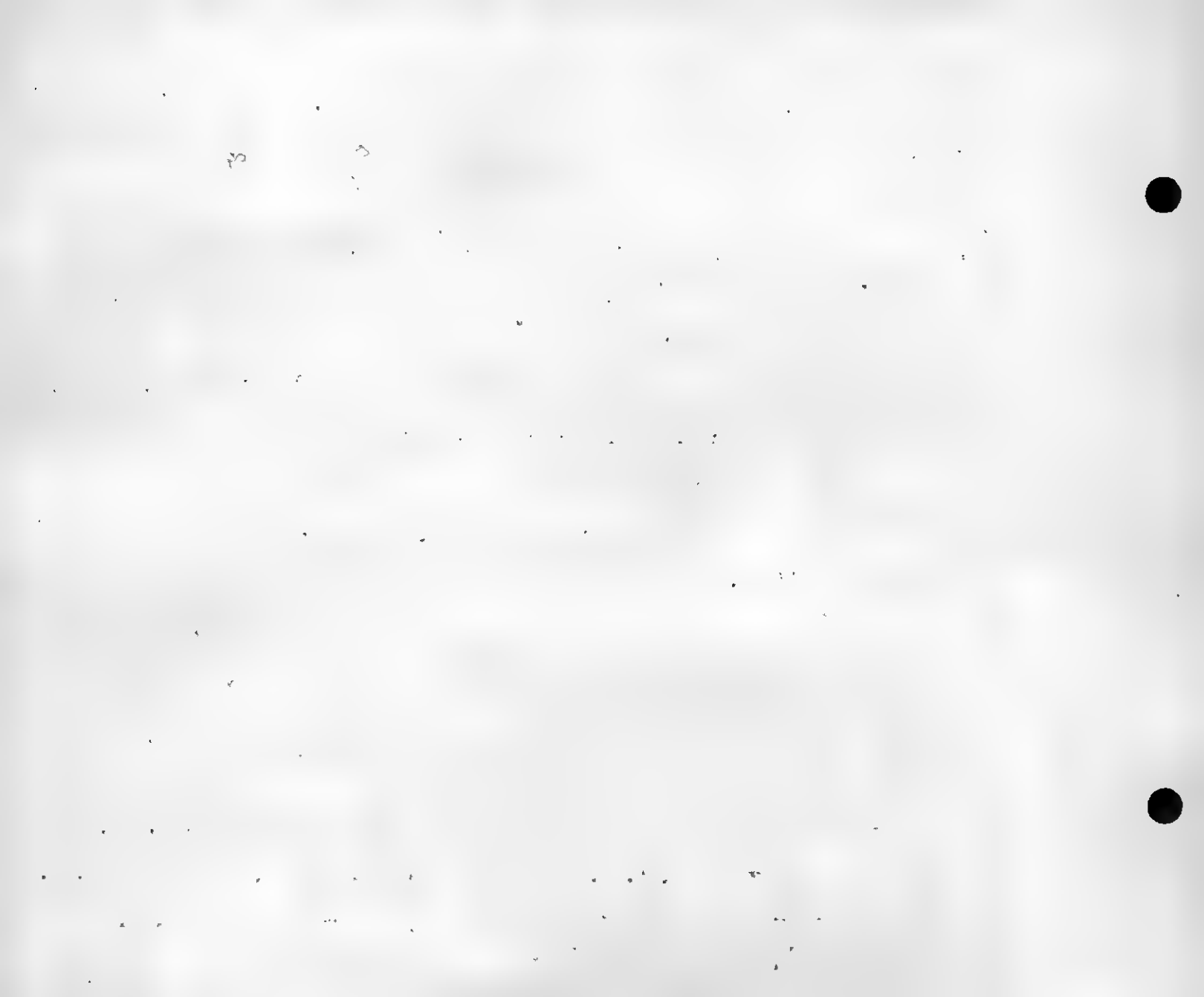
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Items 7a, 7b & 8 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
 FILE G398 2/28/68 kk  
**CERTIFICATE OF DEATH**

02995

1. DECEASED-NAME (Type or print) <i>Loretta A. Ford</i>			2a. DATE OF DEATH Month <i>February</i> Day <i>18</i> Year <i>68</i>			2b. HOUR <i>12:50 A.M.</i>								
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>3-7-98</i>		6. AGE (in years last birthday) <i>69</i> YRS.		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>			7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Prince George</i> Md.					
10. CITY OR TOWN OF DEATH <i>Cheverly, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Prince George General</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>Prince George</i>			13c. CITY OR TOWN <i>College Pk.</i>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <i>6 Locust Lane</i>		
14. FATHER'S NAME First <i>William</i> Middle <i>Bernard</i> Last <i>Wessler</i>			15. MOTHER'S MAIDEN NAME First <i>Lydia</i> Middle <i>Wessler</i> Last <i>Wessler</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT <i>Norma F. Boling</i> Address <i>7405 Kenova St Forestville</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial fibrosis and infarction</i> <i>4107</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary occlusion</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Arteriosclerotic Heart Disease</i> Years <i>18</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Diabetes Mellitus.</i>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 1967</i> , to <i>2-17, 1968</i> , that (I) (we) last saw the deceased alive on <i>2-17, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Peter Duus, M.D.</i>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>FEB. 17, 1968</i>					
22d. PHYSICIAN'S NAME (Type) <i>Peter Duus, M.D.</i>			22e. ADDRESS <i>6056 Central Avenue, Capitol Hghts. Md.</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE <i>2-21-1968</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Soldiers Home Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Washington D. C.</i>					
24. FUNERAL DIRECTOR <i>Robert E. Wilhelm Funeral Home</i> <i>4308 Suitland Road Suitland Maryland</i>						25a. REC'D BY REGISTRAR DATE <i>FEB 23 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and pages and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Clarice			V.		Fraley	February 13, 1968			10:20a
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		8-1-18 8-1-08		59 YRS.		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington, D.C.		U. S. A.				Prince Georges Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Riverdale		Eugene Leland Memorial							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Prince Georges		College Park				1704 Hollywood Road	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Basil					Friel	Emma			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT Address			
						Medical Record/sister			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac thrombosis</u> <u>7 days</u> DUE TO, OR AS A CONSEQUENCE OF <u>Compensated heart failure</u> <u>2 weeks</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis of the</u> <u>2nd branch</u> (c) <u>Arteriosclerosis of the</u> <u>2nd branch</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb 9, 1968</u> to <u>Feb 13, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb 13, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>L W Malin</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>2-13-68</u>			
22d. PHYSICIAN'S NAME (Type) <u>L W MALIN M.D.</u>						22e. ADDRESS <u>Riverdale, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/16/68		Geo. Washington Memo.		Hyattsville Maryland			
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. Wm. Lees Sons, 300 4th St. NE, Wash, DC						FEB 16 1968		<u>Charles Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

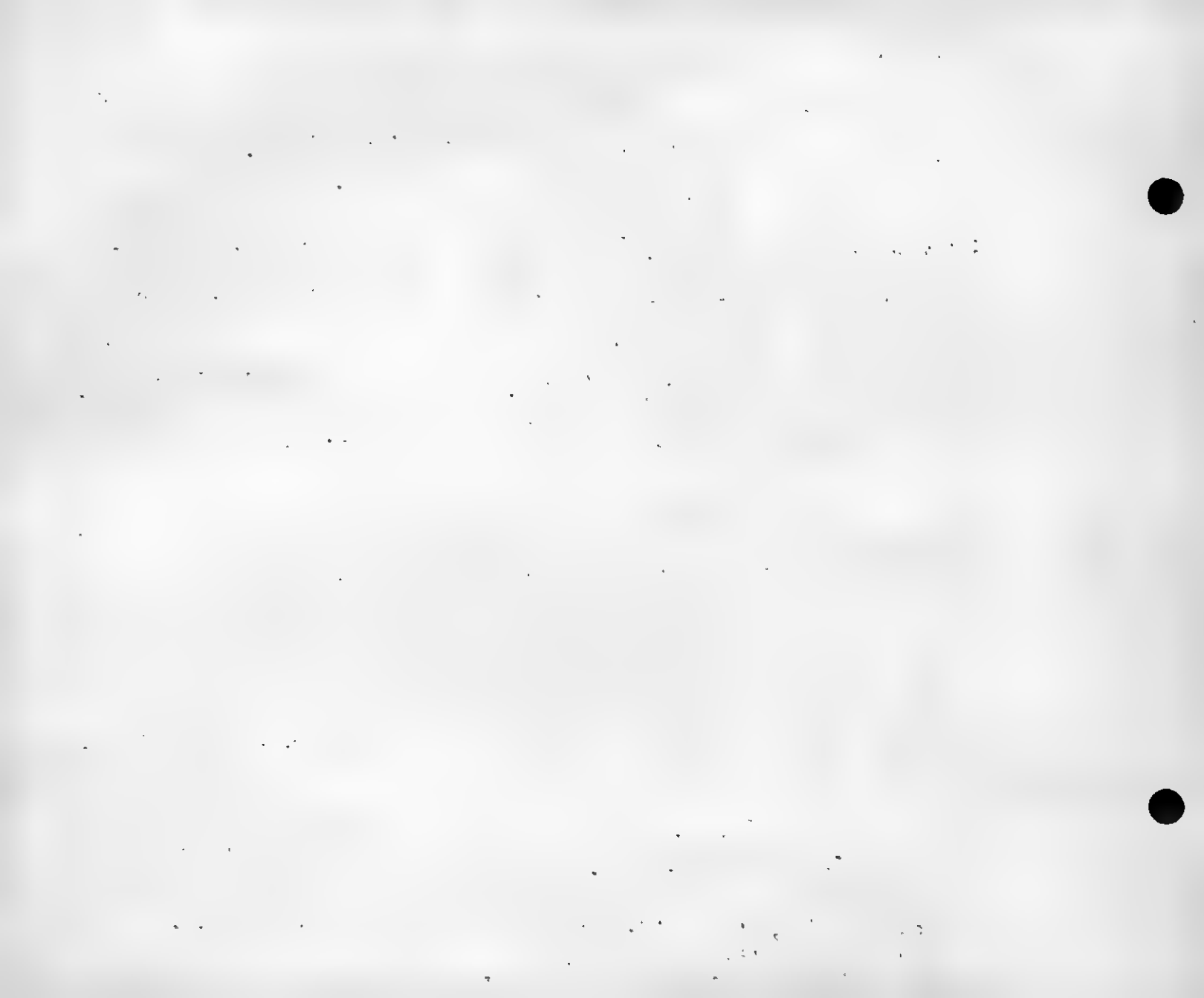
MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or Print)			First Rudolph			Middle Francis			Last Galla			2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> 2 Day 23 Year 1968			2b. HOUR 1:30 P.M.		
3. SEX M		4. RACE W		5. DATE OF BIRTH 6 April 1914		6. AGE (In years last birthday) 53 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month 2 Day 24 Year 1968			2d. HOUR 12:18 A.M.		
7a. BIRTHPLACE (State or foreign country) NEW JERSEY				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Prince George Md					
10. CITY OR TOWN OF DEATH District Heights				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BAKER				12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE N. J.				13b. COUNTY ✓				13c. CITY OR TOWN Irvington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 101 S. 21st st.					
14. FATHER'S NAME First Middle Last ANDREW - GALLA				15. MOTHER'S MAIDEN NAME First Middle Last CATHERINE - GALLA													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b. SOCIAL SECURITY NO				17. INFORMANT ADDRESS MRS. STEPHANIE GALLA-IRVINGTON, N.J.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes 11 yrs.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Metastatic bronchogenic carcinoma over 5 weeks.																	
19a. DATE OF OPERATION 2-10-68				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Liver biopsy for tumor				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE EXAMINER'S NAME (Type) John Kehoe, M.D., Riverdale, Md				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED 2-24-68									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 2/27/1968				23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN				23d. LOCATION (City or Town) (County) (State) HANOVER, NEW JERSEY					
24. FUNERAL DIRECTOR Waham M. Hysong				ADDRESS WASH., D.C.				25a. REC'D BY REGISTRAR DATE FEB 26 1968				25b. REGISTRAR'S SIGNATURE Charles Judge					
HYSONG'S FUNERAL HOME 1300 - N ST., N.W.																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
CHARLES			Jefferson			GARNER		Month 2 Day 2 Year 68 11:35 AM	
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR	
MALE		WHITE		MARCH 9, 1879		88 YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
WASH. D.C.		U.S.A.				PRINCE George's Md			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
HYATTSVILLE		HYATTSVILLE Nursing Home		Retired Architect		Architect			
13a. USUA. RESIDENCE (Where deceased lived if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Montgomery		Silver Spring				905 Patton Drive	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
William Garner			Virginia Weaver						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (No, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		17b. Address			
No		213-38-4001		Mrs. Virginia Mitchell		1713 Silver Spring Drive, Silver Spring, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
<u>Arteriosclerotic Vascular Disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		19							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Jan 1950, to Feb 1968, that (I) (we) last saw the deceased alive on Feb 2 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Bernard A. Fitzgerald MD								2-2-68	
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
BERNARD A. FITZGERALD		217 UNIV. BLVD. E. SIL. SPRING, MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb 6, 1968		Mt. Olivet Cemetery		Washington, D.C.			
24 FUNERAL DIRECTOR		24 ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Warner E. Humphrey, Inc.		34 Georgia Avenue, Silver Spring, Md.		FEB 7 1968					





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 2-7-68		2b HOUR 18:00pm M	
Virginia Groff Gerhold									
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Female	White	11-5-1927	40 YRS					2 Month 8 Day 68 Year 11	45am
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md	
Wash., D.C.		U.S.A.				Prince George's			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Adelphi			2400 Block Mistletoe Lane			Housewife			
13a USUAL RESIDENCE (Where deceased lived, if not institution admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY, MHS?	
Maryland			Prince George's Adelphi					YES <input type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET AND NUMBER			
Chalmers Groff			Sally Baughman			10005 Riggs Road			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT		ADDRESS	
No						Mr. Lee D. Gerhold (above address)			
1B CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Strangulation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>And gun shot wounds of head and chest</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION									19b CONDITION FOR WHICH OPERATION WAS PERFORMED?
19c DATE OF OPERATION									19b CONDITION FOR WHICH OPERATION WAS PERFORMED?
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year HOUR A.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)			
App. 8:00am 2-7-1968			Shot by assailant						
21d NATURE OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No. City or Town County State			
undetermined						Adelphi Prince George Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			2-8-68			
John Kehoe MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
Riverdale Md.			ADDRESS (Street, city, town, or county)						
23a. BURIAL CREMATION REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			
Burial			2/10/68			Fort Lincoln Cem			
24 FUNERAL DIRECTOR			23d LOCATION (City or Town) (County) (State)			25a REC'D BY REGISTRAR			
Valley's Funeral Home Inc.			Colmar Manor, Md.			DATE FEB 13 1968			
ADDRESS			25b REGISTRAR'S SIGNATURE						
Mt. Rainier, Maryland									



FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form BW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										3000	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
George			Giles			2c. DATE PRONOUNCED DEAD			2d. HOUR		
3 SEX			4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7c. COUNTY OF DEATH		
Male			Negro		10-5-1939		28 YRS		Prince George's		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
S.C.			USA						Prince George's		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before death)			13b. CITY OR TOWN			13c. INSIDE CITY CENTS?			13d. STREET AND NUMBER		
District Of Columbia			Washington			YES <input type="checkbox"/> NO <input type="checkbox"/>			1312 Clifton Terrace, N.W.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
?			Elizabeth								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
						Elizabeth Giles - Mother					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Hemorrhagic shock											
DUE TO, OR AS A CONSEQUENCE OF Multiple facial and neck lacerations										hours	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
723 +											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			6:25pm 2-21-68			Passenger of car which went out of control					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
			Baltimore & Washington Parkway near Kenilworth Ave. Prince Geo. Co.								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			22b. DATE SIGNED					
John Kehoe MD			Riverdale, Md.			2-26-68					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Removal			2/27/1968			Ship to			Spartanburg, S.C.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
W. Ernest Jarvis Co.			1432 You Street, N.W.			FEB 29 1968			Charles Judge		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-100. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Etta			Middle May			Last Griggs		
3 SEX Female		4 RACE White		5 DATE OF BIRTH 8/29/17		6 AGE (in years last birthday) 50 YRS		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN	
2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> 2-15-68 19			2b. HOUR 5:10			2c. DATE PRONOUNCED DEAD Month 2 Day 15 Year 68 19			2d. HOUR 5:10 PM		
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's Md		
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince Geo. Gen. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased admission) STATE Maryland			13b. COUNTY Prince George's			13c. CITY OR TOWN Hillside			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME First Middle Last Marshall A. Edwards			15. MOTHER'S MAIDEN NAME First Middle Last Carrie Belle Mitchell			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 579 28 6406		
17. INFORMANT ADDRESS Same as above #13			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201			19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) None					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Cornelius J. Burns, M.D. Acting			CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED Feb. 16, 1968			ADDRESS (Street, city, town, or county) Cheverly, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/19/68			23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln			23d. LOCATION (City or Town) (County) (State) Colmar Manor P.G. Md.		
24. FUNERAL DIRECTOR ADDRESS Francis Gasch's Sons Hyattsville, Md.			25a. REC'D BY REGISTRAR DATE FEB 20 1968			25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers - Pages 1 and 2 - should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

*Dr. Heinrich No. 11111111*

jwb

68017

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

3002

1. DECEASED-NAME (Type or print) <b>Beatrice H. Gugenheim</b>			2a. DATE OF DEATH <b>Feb. Month 28 Day 1968</b>			2b. HOUR <b>AM</b>			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>June 1, 1890</b>		6. AGE (In years last birthday) <b>77 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges Md.</b>			
10. CITY OR TOWN OF DEATH <b>Riverdale</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Leland Memorial</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Anne Arundel</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>335 Cokeland So.</b>	
14. FATHER'S NAME First Middle Last <b>James McGinty</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Duffy</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		16b. SOCIAL SECURITY NO <b>207-07-2929D</b>		17. INFORMANT Address <b>James A. Gugenheim 335 Cokeland So. Laurel, Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HYPERTENSIVE CARDIAC DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>over 5 years</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>2-10-66</b> 19, to <b>2-2-68</b> 19, that (I) (we) last saw the deceased alive on <b>2-2-68</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Wm. C. Weintraub</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-29-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Wm. C. Weintraub</b>				22e. ADDRESS <b>Greenbelt, Maryland</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>3/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Wilkes Barre Pa.</b>			
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons</b>				ADDRESS <b>Hyattsville, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 4 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Francis Gasch</i>	





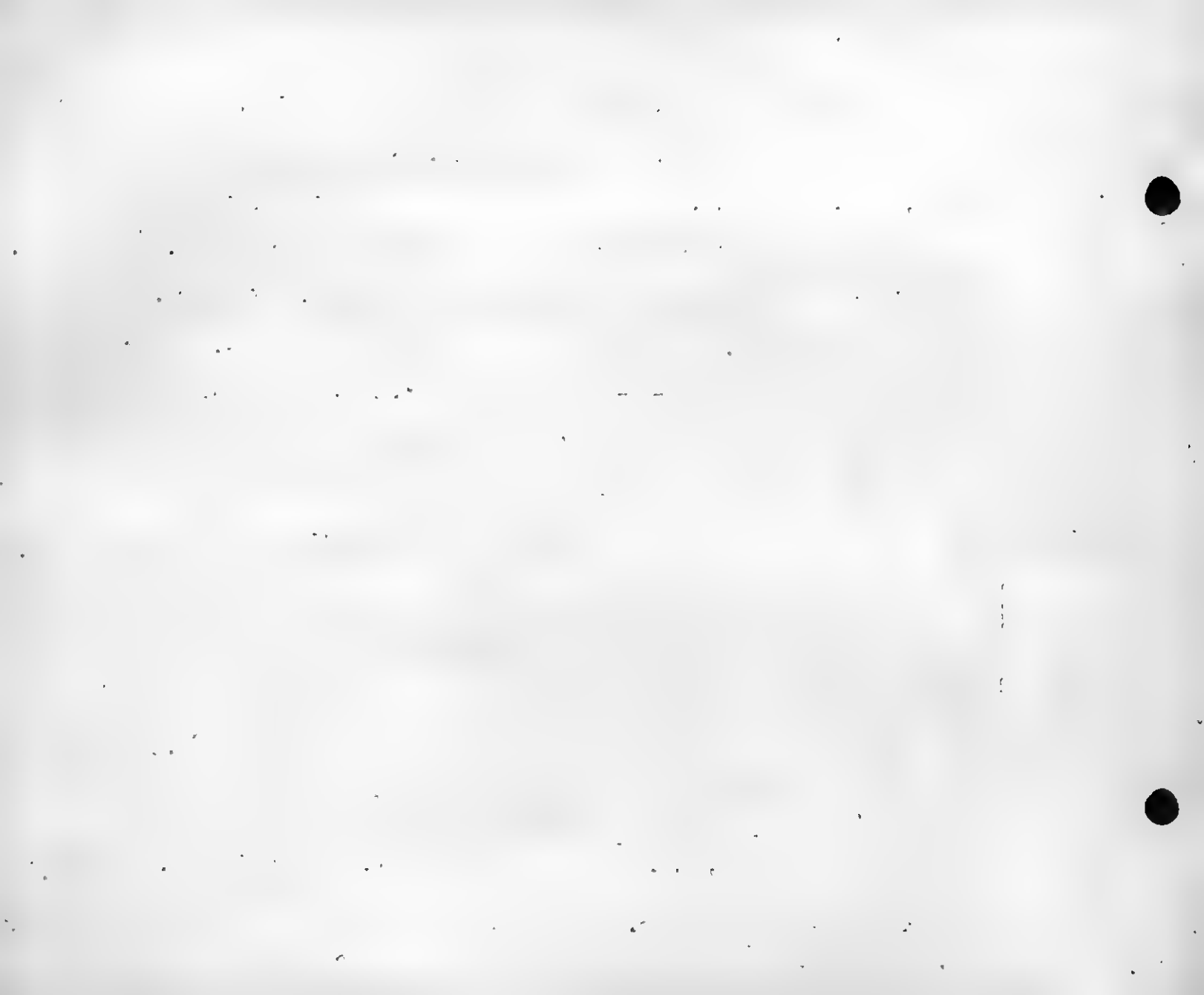
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner-Notified

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Lost	20. DATE OF DEATH			2b. HOUR
HARRY RUTLEDGE HALL						FEB. 14 1968			5:30A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. UNDER 1 YEAR	
MALE		CAU.		29 Oct. 1885		82 YRS.		MONTHS DAYS HOURS M N	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Boston, Mass.		U.S.				PRINCE GEORGE Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR IND. STRY			
HYATTSVILLE		5600-42nd Ave.		Chief Engineer Wash.		Santi. Comm.			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland		Prince George		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5600- 42nd Ave.	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
Frank H. Hall						Elizabeth C. Henderson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
NO		220-34-4993		Margaret W. Hall		Same as above Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <u>Coronary atherosclerosis</u> (b) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>Coronary atherosclerosis</u> (c) <u>Coronary atherosclerosis</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , to <u>1968</u> , that (I) (we) last saw the deceased alive on <u>1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. DEGREE	
<u>Donald P. Edgren M.D.</u>		<u>2-15-68</u>		<u>PRINCE GEORGE</u>		<u>Prince Geo. Plaza Shopg Ctr. Hyattsville Md.</u>		<u>M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2-16-68		Ft. Lincoln Cemetery		Colmar Manor Maryland			
24. FUNERAL DIRECTOR		F. Gasch's Sons		Hyattsville, Maryland		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
						FEB 19 1968		<u>Atlanta Judge</u>	



# FOR STATE HEALTH DEPT.

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 Items 7a & 7b Film Copy 270684

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Millard Fillmore Hairston						Month Day Year			2 10 1968 5:30 a.m.		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
male	Negro	4-12-11	56 YRS	MONTHS	DAYS	HOURS	MIN.	Month Day Year			5:30 a.m.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Martinsville, Va.		USA				Prince George's Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George's Gen. Hosp.								
13a. U.S.A. RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			P.G.			St. Pleasant			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER					
First Middle Last			First Middle Last			1012 Addison Road					
Millard F. Hairston Sr.			Lucy A. Hairaton								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Yes			Will			Mrs. Rosa Byrd, P.O. Box 492, Martinsville, Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Subdural and Subarachnoid hemorrhage											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										3 1/2 hours	
(b) Trauma											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				2:00 P.M. AM 2-10-68				hit over head by assailant			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				home				1012 Addison Road, St. Pleasant, P.G. Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				M.D.				22b. DATE SIGNED			
EXAMINER'S NAME (Type) John Kehoe M.D., Livonia, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				2-11-68			
ADDRESS (Street, city, town, or county)											
23a. B. RIAL CREMATION, BURIAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				Feb. 14, 1968				Peoples Cemetery			
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REG. STRAR			
William Elmer				814 Franklin Street Alexandria, Va.				DATE FEB 13 1968			
								25b. REGISTRAR'S SIGNATURE			



## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>JOSEPH W. HARRISON SR.</b>			2a. DATE OF DEATH Month <b>Feb</b> Day <b>22</b> Year <b>1968</b>			2b. HOUR <b>7:50 PM</b>	
3. SEX <b>MALE</b>		4. RACE <b>W. WHITE</b>		5. DATE OF BIRTH <b>9-24-06</b>		6. AGE (In years last birthday) <b>61</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>WASH. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGE</b> Md.	
10. CITY OR TOWN OF DEATH <b>HILLCREST HTS. MD.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HILLCREST HTS.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>PLUMBER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PLUMBING</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Res'dence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>PRINCE GEORGE</b>		13c. CITY OR TOWN <b>HILLCREST HTS.</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>5901 27TH AVE</b>		14. FATHER'S NAME First Middle Last <b>PERCY HARRISON</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>NELLIE BAUR</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>ANN C HARRISON</b> Address <b>5901 27TH AVE HILLCREST HTS. MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>18X X</b> DUE TO, OR AS A CONSEQUENCE OF <b>Chokepne</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Concussion of bladder &amp; intestines</b> (b) <b>19 months</b> DUE TO, OR AS A CONSEQUENCE OF <b>19 months</b> (c) <b>19 months</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>19 months</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>2/21/68</b> to <b>2/22/68</b> , that (I) (we) last saw the deceased alive on <b>2/21/68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did not) view the body after death.							
22b. SIGNATURE <b>Stewart L. LANE</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/23/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Stewart L. LANE</b>				22e. ADDRESS <b>30066 12 ST. N.W. WASHINGTON, D.C.</b>			
23a. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>Feb. 26 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CECILE HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>SWITLAND, MD.</b>	
24. FUNERAL DIRECTOR <b>J. Wm. Lee Sons</b>				ADDRESS <b>3004th St. N.E. Wash, D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 28 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove death papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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03021

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3005

1 DECEASED NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI DEATH MATED <input checked="" type="checkbox"/> 2-2-68 1911			2b. HOUR 00aM
Willie Louis Harrison									
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD Month 2 Day 2 Year 68 1911	2d. HOUR 11aM
Male	Negro	11 Sept. 1893	74 YRS						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> W-DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md
North Carolina		USA				Prince George's			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince George Hospital			Minister			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER		
District of Columbia			Washington				1915 Central Ave., N.E.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Louis Harrison						Henrietta Whitaker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT			ADDRESS
						Willie L. Harrison, Jr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4200 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 5 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes mellitus - over 4 yrs.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> HOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			22b. DATE SIGNED			
John Kehoe			John Kehoe, M.D. Riverdale, Md.			2-2-68			
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			2/6/68		Carver Memorial Park		Maryland		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Stewart Funeral Home-4001 Benning Rd.,			FEB 7 1968			John T. Stewart			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>PRINCE GEORGE</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PR. GEORGE</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HYATTSVILLE</u>						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL MANOR-4922 LA SALLE RD.</u>						d. STREET ADDRESS <u>3509-5T. JOHN'S PLACE</u>					
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>L.</u> Last <u>HAUPT</u>						4. DATE OF DEATH Month <u>FEB.</u> Day <u>14<sup>th</sup></u> Year <u>1968</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 5, 1881</u>		9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>JAMES P. CRICKARD</u>						14. MOTHER'S MAIDEN NAME <u>MARGARET A. NEHIGAN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>170-40-4957</u>		17. INFORMANT Address <u>SR. BERNADETTE JOSEPH-CARROLL MANOR-</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4100</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 year</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>Jan. 16</u> , 19 <u>67</u> , to <u>Feb. 14</u> , 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>Feb. 12</u> , 19 <u>68</u> , and that death occurred at <u>2:20</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Thomas F Collins</u>										22b. DATE SIGNED <u>Feb. 14, 1968</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas F Collins, M.D.</u>						22d. ADDRESS <u>322 H St. N.E., Washington, D.C. 20002</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>FEB. 16, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>HOLY SAVIOR CEM.</u>			23d. LOCATION (City, town or county) (State) <u>YORK, PENN.</u>			
24. FUNERAL DIRECTOR <u>HANLON FUNERAL HOME-WASH. D.C.</u>						25a. REG'D BY REGISTRAR AND 25b. REGISTRAR'S SIGNATURE <u>FEB 19 1968</u> DATE					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										3008		
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or Print)			First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR	
Anna Marie Heiss									2-10-68		194:30am	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		2d. HOUR		
Female	White	26 Feb. 1962	5 YRS	MONTHS	DAYS	HOURS	MIN.	Month 2 Day 10 Year 68		198:15am		
7a. BIRTHPLACE (State or foreign)			7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Washington D. C.			U. S. A.				Prince George's Md.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince George Hospital			none						
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Prince George			Palmer Park		YES <input type="checkbox"/> NO <input type="checkbox"/>		8021 Allendale Drive		
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME			
Hugh Howard Heiss									Louise Virginia Stephens			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT ADDRESS						
no			none			Louise V. Stephens Same as #13 (mother)						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonitis												
486X DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
492X												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?						
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
			HOUR A.M. P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.			City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			John Kehoe MD			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			2-12-68			
			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial			2/13/68		Ft. Lincoln		Colmar Manor, P.G.				Md.	
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE				
Francis Gasch's Sons Hyattsville, Md.						FEB 15 1968		Charles Judge				



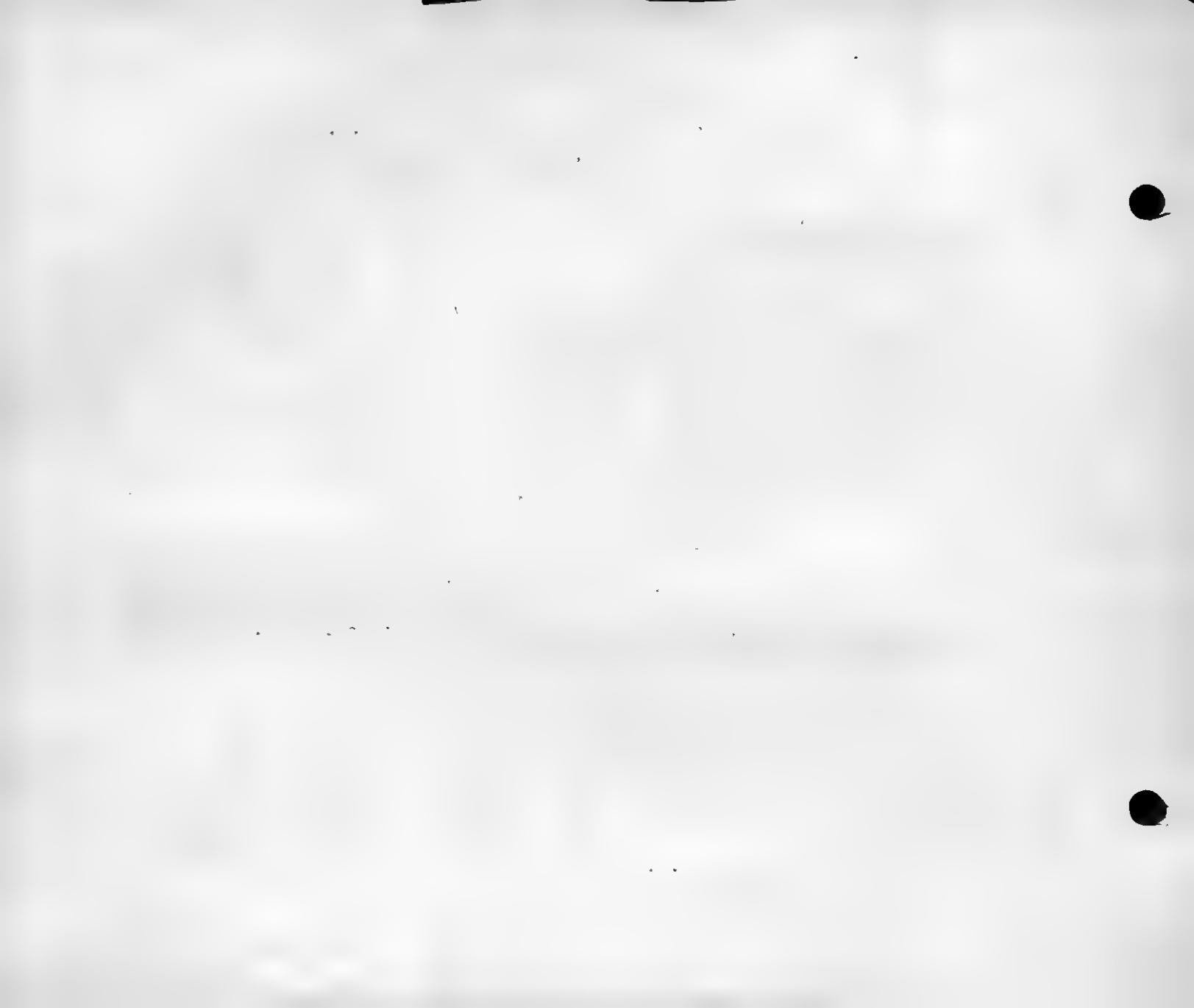
## CERTIFICATE OF DEATH

J3012

1 PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>D.C.</b> b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>	
c. LENGTH OF STAY in 1b <b>3yrs, 4mos, 20days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		d. STREET ADDRESS <b>No fixed Address</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edith Herndon</b>		4. DATE OF DEATH Month <b>February</b> Day <b>16</b> Year <b>19 68</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/21/96</b>
9. AGE (In years lost birthday) <b>72</b> yrs		10. IF UNDER 1 Year Days <b>16</b> Hours <b>19</b> Min <b>68</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frederick Robinson</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Hevron</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO <b>578-03-1133</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>coronary artery disease</b> DUE TO (c) <b>generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>years</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Recurrent cerebrovascular accidents with encephalomalacia; diab. mell., mild; probable pulmonary embolism, multiple, old.</b> WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>9/4 / 1964</b> , to <b>2/16</b> , 19 <b>68</b> , that <del>we</del> (we) last saw the deceased alive on <b>2/16</b> 19 <b>68</b> , and that death occurred at <b>925A</b> M, from causes and on the date stated above			
22a. SIGNATURE <i>Moe Weiss</i>		22b. DATE SIGNED <b>2/16/68</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>2/21/68</b>		23b. DATE THEREOF <b>Lincoln Memorial</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Suitland, Maryland</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <i>Henry W. Jaynes</i>		25a. REC'D BY REGISTRAR <b>FEB 21 1968</b>	
25b. REGISTRAR'S SIGNATURE <i>John A. Jones</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

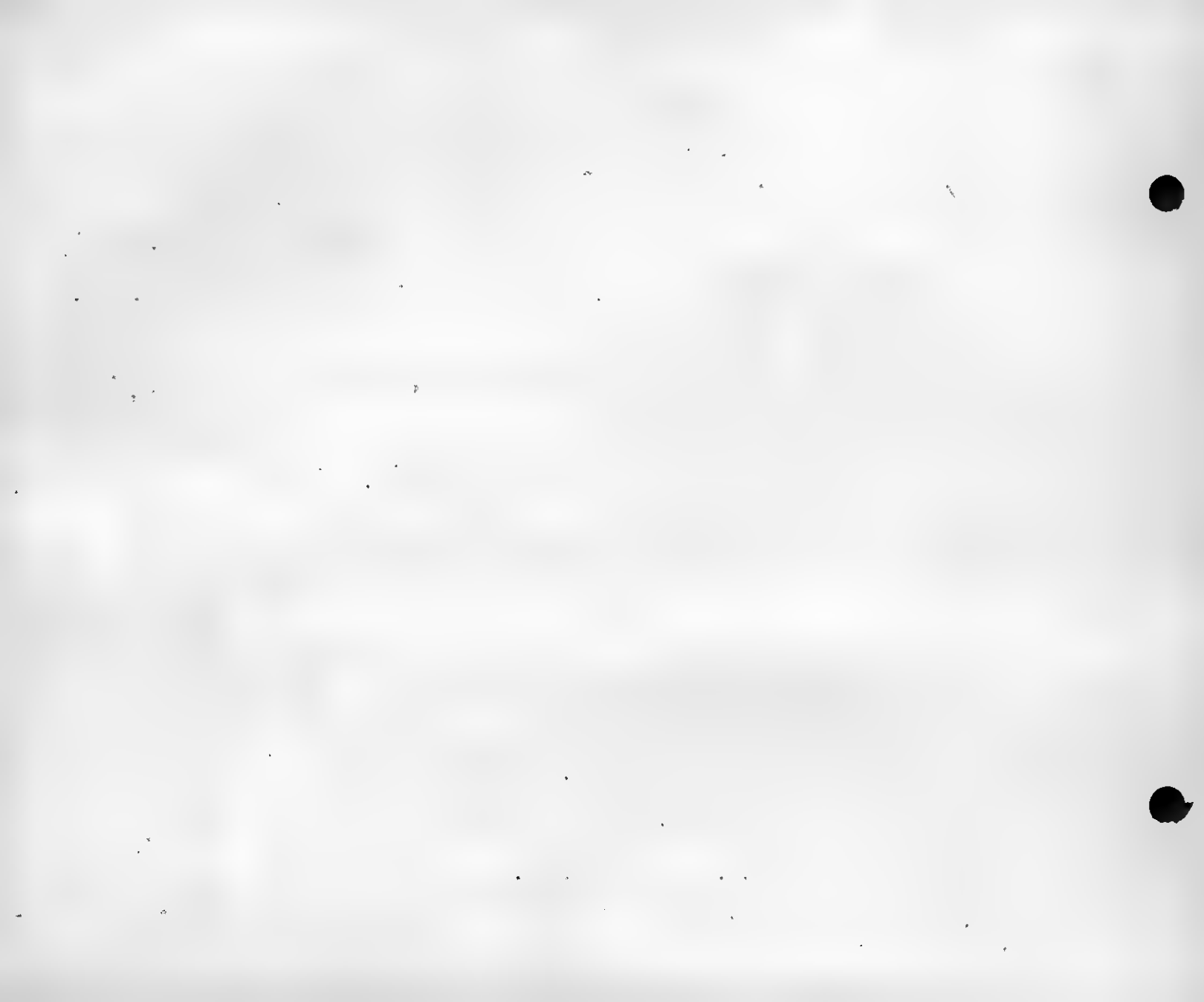
3009

FOR STATE HEALTH DEPT.

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1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		Month		Day		Year		2b HOUR			
Agnes Loretta Hildebrand								2-6-68		19		7		55am					
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (in years last birthday)		F UNDER 1 YEAR		F UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		Year			
Female	White	2-26-1903		64 YRS		MONTHS		DAYS		2		6		68		8:04am			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH													
PENN'A		U.S.				Prince George's													
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY													
Cheverly		Prince George Hospital		CLERK		GEN. ACD. U.S.													
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) - STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER											
Maryland		Prince George		Riverdale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5600 54th. Ave. Apt. 404											
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First		Middle		Last					
MARK		ROURKE						UNKNOWN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		UNKNOWN		MR JAMES F. HILDEBRAND		5408 76th COURT LANHAM, MD													
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure																minutes			
Cond it ions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																over 10 yrs.			
DUE TO, OR AS A CONSEQUENCE OF Hypertensive arteriosclerotic heart disease																			
DUE TO, OR AS A CONSEQUENCE OF																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION																19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY?	
																		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
				19 P.M.															
21d INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No				City or Town							
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>												County							
												State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE				John Kehoe M.D.				CHIEF MED CAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED							
								ASS STANT MEDICAL EXAMINER <input type="checkbox"/>				2-6-68							
EXAMINER'S NAME (Type)				John Kehoe M.D.				DEPUTY MED CAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)							
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CRIMATORY				23d LOCATION (City or Town) (County) (State)							
BURIAL				10 FEB 1968				FORT LINCOLN CEM				COLMAR MANOR, MARYLAND							
24. FUNERAL DIRECTOR				ADDRESS				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE							
W.W. CHAMBERS CO.				RIVERDALE, MARYLAND				DATE FEB 13 1968											

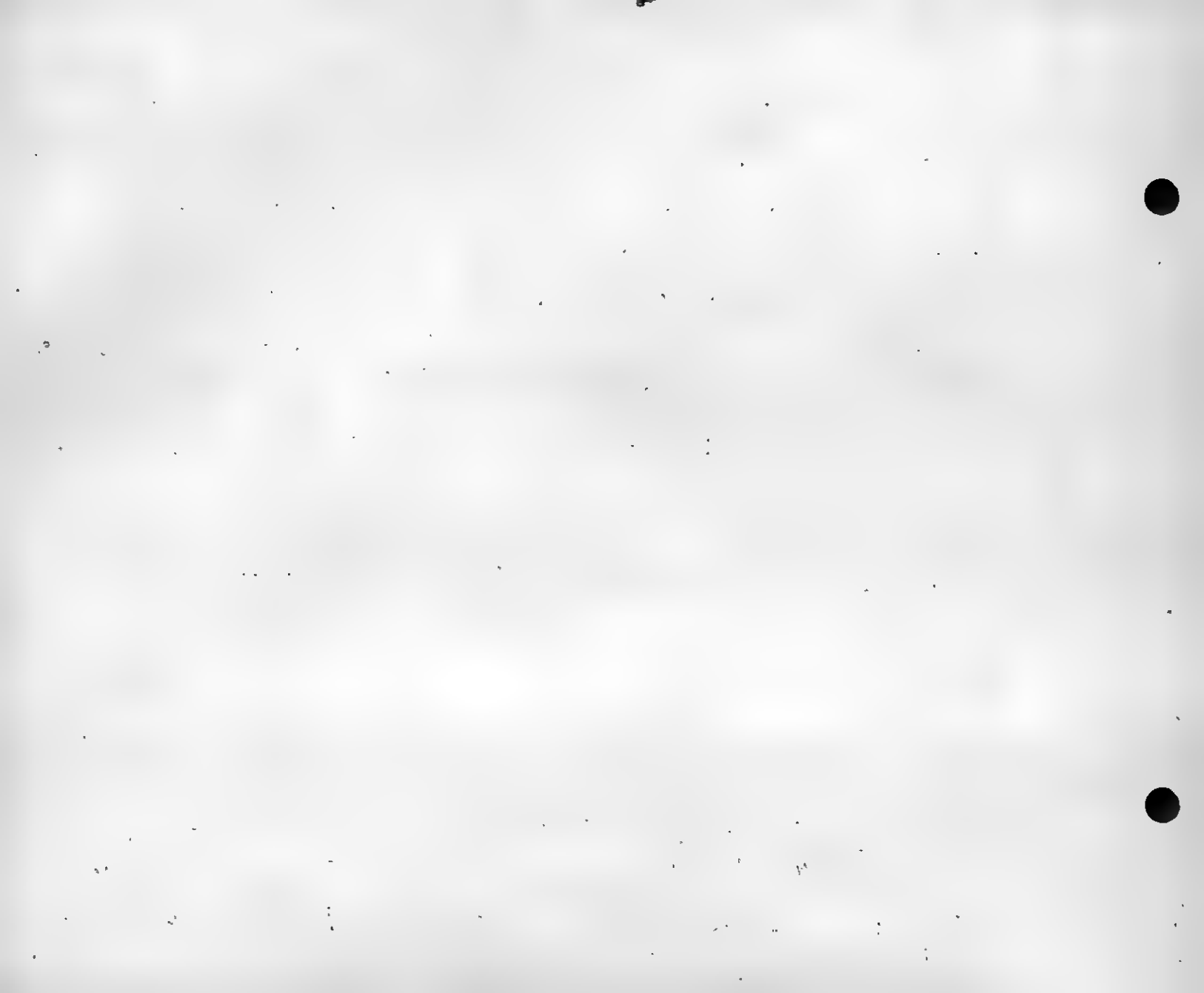




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR
Caroline			Hinck			Feb. 7 1968			5:30 A.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		White		Nov. 6, 1879		88 YRS.		- - - -	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York		U.S.A.				Pr. Georges, Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Greenbelt			Greenbelt Conv. Center			Housewife			-
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			PRINCE GEORGES			Bowie		2808 Spiral Lane	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
UNKNOWN			HOMER			UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT		Address	
NO			NONE			VIOLET DAVIS		SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pancreas</u> 1579 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>157X</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Arteriosclerotic cerebral vascular disease</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 10, 1967</u> to <u>Feb 7, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb 1, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Leonard Appel MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <u>Feb 7, 1968</u>		
22d. PHYSICIAN'S NAME (Type) <u>LEONARD APPEL</u>				22e. ADDRESS <u>3231 SUPERIOR Lane. Bowie Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
BURIAL		10 FEB 1968		PEGUES UNION CEM			VIENNA, NEW JERSEY		
24. FUNERAL DIRECTOR <u>W.W. Chambers Co</u>				ADDRESS <u>Riverside, Md.</u>			25a. REC'D BY REGISTRAR <u>FEB 13 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

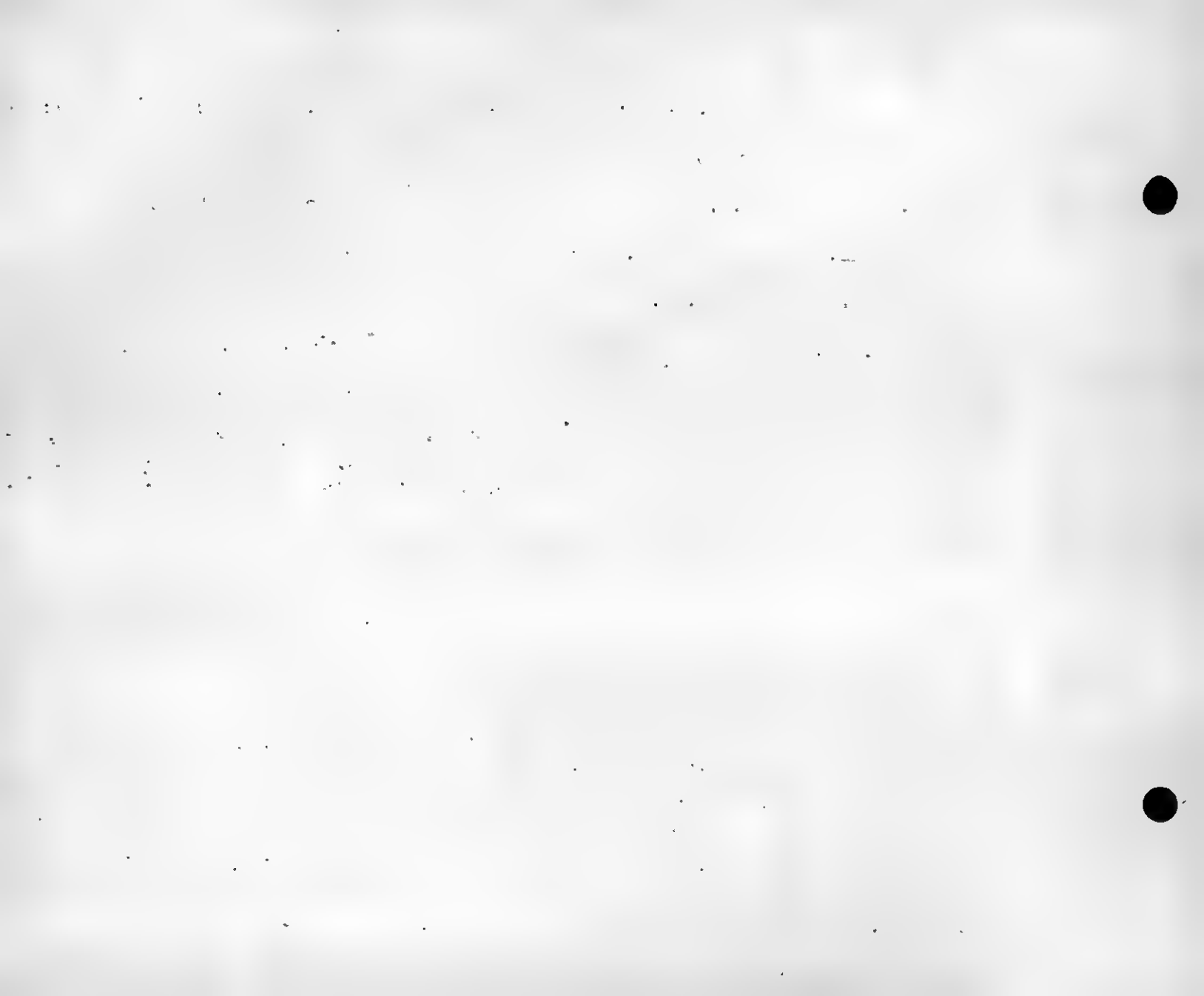
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33027

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

03013

1 DECEASED-NAME (Type or print) First Middle Last <b>Thomas Harley Hopkins</b>			2a. DATE OF DEATH Month Day Year <b>Feb. 10 68</b>			2b. HOUR <b>4:40A</b>			
3 SEX <b>male</b>		4 RACE <b>white</b>		5 DATE OF BIRTH <b>12/1/10</b>		6. AGE (In years lost birthday) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's County Md.</b>			
10. CITY OR TOWN OF DEATH <b>Riverdale.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>E. Leland Memorial</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if ret. red.) <b>Repairman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Mobile Homes</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>P. G.</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rt2 Box 276</b>	
14. FATHER'S NAME First Middle Last <b>George Hopkins</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mattie V. Milbrook</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17 INFORMANT Name Address <b>Charles E. Milbrook, Laurel Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Which coronary thrombosis I have</b> <b>41</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerosis &amp; atherosclerosis 27%</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 31</b> , 19 <b>67</b> , to <b>Feb 10</b> , 19 <b>68</b> , that (I) (we) lost the deceased alive on <b>Feb 10</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>L. W. Mahan</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-10-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>L. W. Mahan M.D.</b>		22e. ADDRESS <b>Riverdale, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-13-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Long Hill Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Laurel Md.</b>			
24. FUNERAL DIRECTOR <b>Robert R. Roudsman</b>		ADDRESS <b>Laurel Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

38028

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

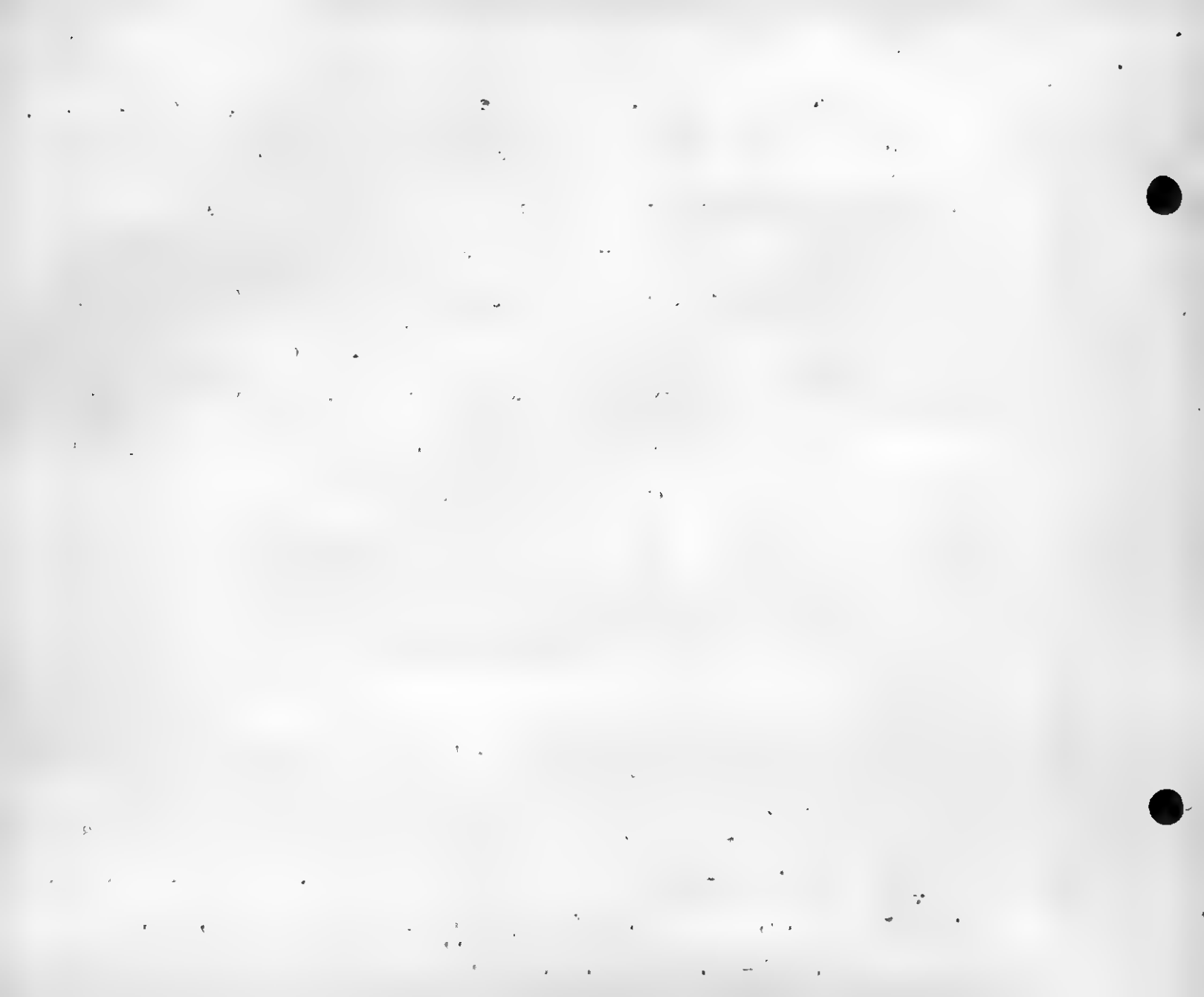
1. DECEASED-NAME (Type or print) <u>MARIE I HORNING</u>			2a. DATE OF DEATH Month <u>Feb.</u> Day <u>13</u> Year <u>1968</u>			2b. HOUR M				
3 SEX <u>Female</u>		4 RACE <u>white</u>		5. DATE OF BIRTH <u>OCT. 4, 1876</u>		6. AGE (In years last birthday) <u>91</u> YRS		F UNDER YEAR MONTHS <u>91</u> DAYS <u>91</u> HOURS <u>91</u> MIN.		
7a. BIRTHPLACE (State or foreign country) <u>Potomac Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>PRINCE GEORGES.</u> Md				
10. CITY OR TOWN OF DEATH <u>HYATTSVILLE</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>CARROLL MANOR</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Book Keeper</u>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>D.C. Washington</u>			13b. COUNTY <u>✓</u>		13c. CITY OR TOWN <u>✓</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>4801 CONN. AVE.</u>	
14. FATHER'S NAME First <u>JAMES</u> Middle <u>BURNS.</u> Last <u>HENRY</u>			15. MOTHER'S MAIDEN NAME First <u>MARTHA</u> Middle <u>JANE</u> Last <u>HENRY</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO. <u>227-14-3583</u>		17. INFORMANT <u>A.M. Dolone</u>		Address <u>4922 La Salle Pl.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. <u>433.9</u> IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>years</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) <u>534.1</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUT NG <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING ETC)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>65</u> , to <u>2/13</u> , 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>2/12</u> , 19 <u>68</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) (did not) view the body after death.										
22b. SIGNATURE <u>John W Winkler Jr MD</u>						22c. DATE SIGNED <u>2/13/68</u>		22d. PHYSICIAN'S NAME (Type) <u>JOHN W WINKLER JR MD</u>		
22e. ADDRESS <u>5800 10th PL HYATTSVILLE MD</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>			23b. DATE <u>2/15/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>		
24. FUNERAL DIRECTOR <u>H. K. Huntemann &amp; Son</u>						25. REC'D BY REGISTRAR <u>FEB 16 1968</u>		26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Ella</b> First Middle Last					2a. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1968</b>			2b. HOUR <b>6:p.</b> M	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 12, 1882</b>		6. AGE (In years last birthday) <b>85</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George</b> Md			
1d. CITY OR TOWN OF DEATH <b>Hyattsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Sacred Heart Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>D.C.</b> DISTRICT OF COLUMBIA			13b. COUNTY <b>Washington</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1501 27th Street, S.E.</b>		
14. FATHER'S NAME First <b>Michael</b> Middle <b>Dempsey</b> Last				15. MOTHER'S MAIDEN NAME First <b>Margaret</b> Middle <b>McAuliffe</b> Last					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>578-66-5708</b>		17. INFORMANT Address <b>Sacred Heart Home, Hyattsville, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Carcinoma of the Bowel</b> <b>155.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>14 Months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 14, 1967</b> to <b>Feb. 3, 1968</b> , that (I) (we) last saw the deceased alive on <b>January 27, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Thomas F. Collins MD</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>February 3, 1968</b>				
22d. PHYSICIAN'S NAME (Type) <b>Thomas F. Collins</b>					22e. ADDRESS <b>322 H Street, N.E. Washington, D.C.</b>				
23a. BURIAL CREMATION <b>BURIED</b>		23b. DATE <b>Feb. 6, 68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, DC.</b>			
24. FUNERAL DIRECTOR <b>Simmons Bros.</b> ADDRESS <b>1661-Gd. Hope Rd. SE. DC.</b>					25a. REC'D BY REGISTRAR <b>FEB 6 1968</b> DATE		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

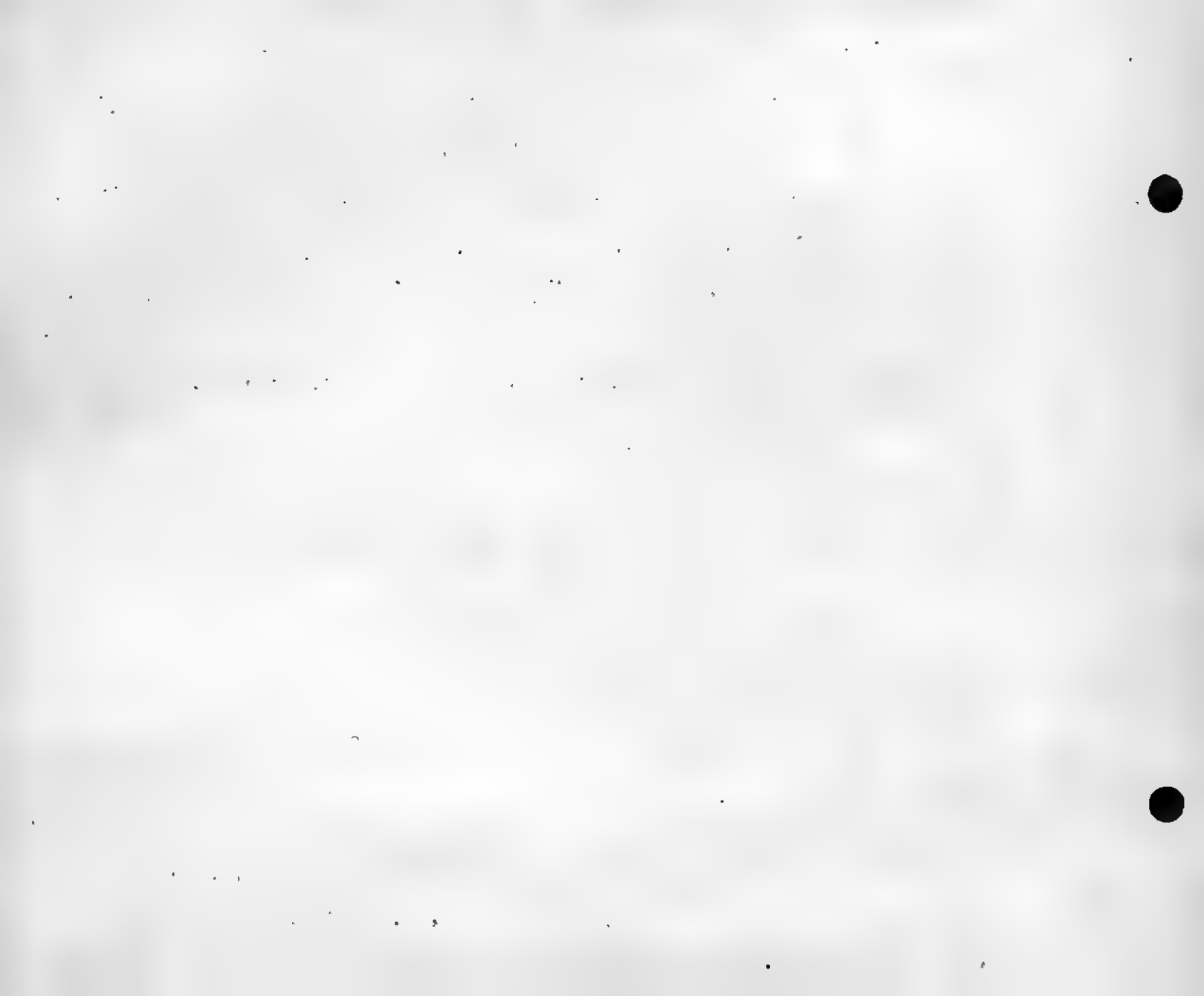




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

JACKSON										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH										30115									
1 DECEASED NAME (Type or print)					First Middle Last					2a DATE OF DEATH					2b HOUR				
PETER					ANTHONY JACKSON					Month Day Year					FEB 24 1968 1710 M				
3 SEX			4 RACE			5. DATE OF BIRTH			6 AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.				
MALE			CAU			15 AUG 1937			30 YRS.										
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH										
N.Y.C.			UNITED STATES						PRINCE GEORGES Md										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY										
ANDREWS AFB - MARYLAND			MALCOLM GROW USAF WOSP.			USAF													
13a. USUAL RESIDENCE (Where deceased lived, if institution admssion) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER							
MARYLAND			PRINCE GEORGES			CAMP SPRINGS			YES			5009 THURMAN DR.							
14 FATHER'S NAME First Middle Last					15 MOTHER'S MAIDEN NAME First Middle Last														
(DEC.) HENRY LOUIS JACKSON					(DEC.) VIVIAN DANHAUSER														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)					16b. SOCIAL SECURITY NO					17 INFORMANT					Address				
(Yes no, or unknown)					009-26-1834					JOAN B. JACKSON					5009 Thurman Dr. Camp Springs, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) <u>HODGKINS DISEASE</u>										18 mths									
DUE TO, OR AS A CONSEQUENCE OF																			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.																			
(b) DUE TO, OR AS A CONSEQUENCE OF																			
(c)																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)					21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19					21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)					21f. LOCATION Street or R.F.D. No. City or Town County State									
22a. I certify that (X) (this hospital) attended the deceased from <u>26 October 19 67</u> , to <u>24 Feb 68</u> , that (X) (we) last saw the deceased alive on <u>24 Feb 19 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <u>[Signature]</u> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>										22c. DATE SIGNED <u>24 Feb 68</u>									
22d. PHYSICIAN'S NAME (Type) RUBEN ALTMAN, CAPT, USAF MC										22e. ADDRESS MALCOLM GROW USAF HOSPITAL ANDREWS AFB, WASH, D.C. 20331									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City or Town) (County) (State)				
Burial					2/28/68					Arlington Natl. Cem.					Arlington, Virginia				
24. FUNERAL DIRECTOR ADDRESS										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Falls Church F.H., Falls Church, Va.										FEB 27 1968					[Signature]				



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

301

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-2. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year			2b HOUR		
Thomas Bedford Jeffries									2c DATE PRONOUNCED DEAD Month Day Year		
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (In years last birthday)		
male			white			5-18-1909			58 YRS		
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
DISTRICT 4, COL			U.S.						Prince George's Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Riverdale			Leland Memorial Hospital			MANAGER			NEWS CENTER		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before)			13b CITY OR TOWN			13c INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER		
Maryland			Prince George's College Park						3703 Marlboro Road WAY		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
HENRY R. JEFFRIES			ELEANOR G. GODE								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
NO			577 051154			MAE D. JEFFRIES			SAME AS #13		
18 CAUSE OF DEATH (Enter on y one cause per line for (a) (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure										minutes	
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease										unknown	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
42											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				19 P.M.							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED			
EXAMINER'S NAME (Type) John Kehoe MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				2-8-68			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a BURIAL CREMATION REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY			
BURIAL				10 FEB 1968				FORT LINCOLN CEM			
24 FUNERAL DIRECTOR				23d LOCATION (City or Town) (County) (State)				25a REC'D BY REGISTRAR			
W.W. CHAMBERS CO. RIVERDALE, MARYLAND				COLMAR MANOR, MARYLAND				FEB 13 1968			
				25b REGISTRAR'S SIGNATURE							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

33018

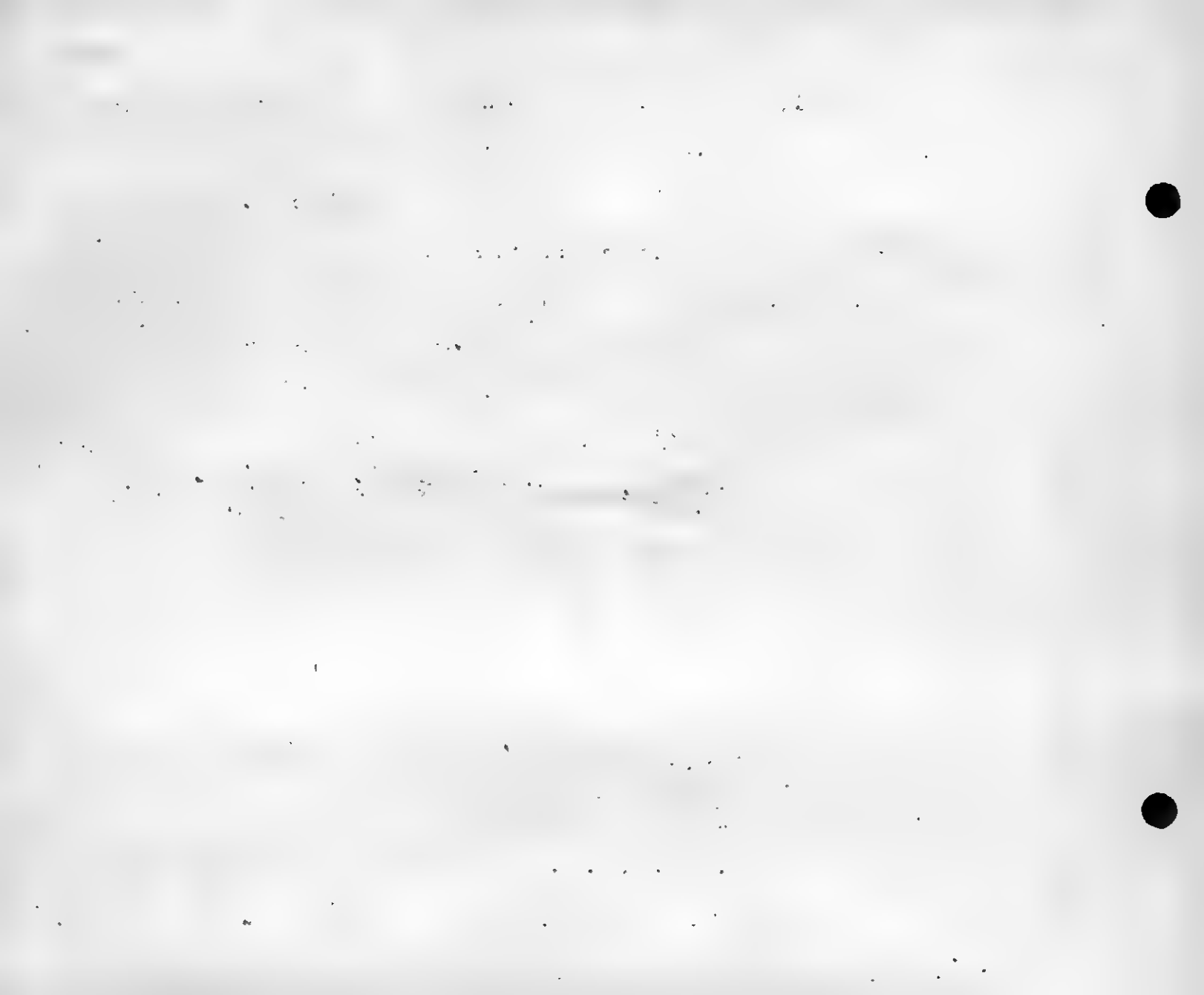
1 DECEASED NAME (Type or print) <b>Grace P. Johnson</b>			2a. DATE OF DEATH <b>Feb. 21, 1968</b>		2b. HOUR <b>12:10 M</b>			
3. SEX <b>Female</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>July 7, 1882</b>		6. AGE (In years last birthday) <b>86 8 YRS</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Missouri</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b>		Md.
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>DOA Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Landover</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4007 73rd Avenue</b>
14. FATHER'S NAME First Middle Last <b>William Elerdrige</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Jane A Waltz</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Pearlie Miller Dau.</b>		Address <b>Hyattsville, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Acute Coronary Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes.</b> <b>10 years.</b>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes Mellitus</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>June, 1964</b> , to <b>21 Feb. 1968</b> , that (I) (we) lost saw the deceased alive on <b>7 Feb. 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>Thomas G. Maloney, M.D.</b>				22c. DATE SIGNED <b>21 Feb 68</b>		22d. PHYSICIAN'S NAME (Type) <b>Thomas G. Maloney, M. D.</b>		
22e. ADDRESS <b>4814 71st Ave., Landover Hills, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>Feb. 22, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>McCurry Funeral Home</b>		23d. LOCATION (City or Town) (County) (State) <b>Brunswick, Chariton, Missouri</b>		
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <b>Susie E. Johnson</b>				2a. DATE OF DEATH Month <b>February</b> Day <b>24</b> , Year <b>1968</b>				2b. HOUR <b>9:10AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>11/1/88</b>		6. AGE (In years last birthday) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS HOURS <b></b> MIN. <b></b>	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen. Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>Dist. of Columbia</b> 13b. COUNTY <b>Prince Georges</b>			13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1016 65th Pl., N.E.</b>				
14. FATHER'S NAME First <b>Ernest</b> Middle <b>Goins</b> Last <b>Goins</b>				15. MOTHER'S MAIDEN NAME First <b>Unknown</b> Middle <b>Hammond</b> Last <b>Mc</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes no, or (unknown) <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Christine Chinn</b> Address <b>6006 Galveston Rd</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Thrombosis</b> <b>412.0</b> DUE TO, OR AS A CONSEQUENCE OF - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (X) (this hospital) attended the deceased from <b>2/20</b> , 19 <b>68</b> , to <b>2/24</b> , 19 <b>68</b> , that (X) (we) lost saw the deceased alive on <b>February 24</b> , 19 <b>68</b> , and that in (X) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William D. Rosson</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/24/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>William D. Rosson, M. D.</b>				22e. ADDRESS <b>Prince Georges General Hospital</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>2-28-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>		23d. LOCATION (City or Town) (County) (State) <b>Highland Park Md</b>					
24. FUNERAL DIRECTOR <b>H.S. Washington + Jr 4925 Deane</b>						25a. REC'D BY REGISTRAR <b>DAAR</b>		25b. REGISTRAR'S SIGNATURE <b>1 1968</b>			



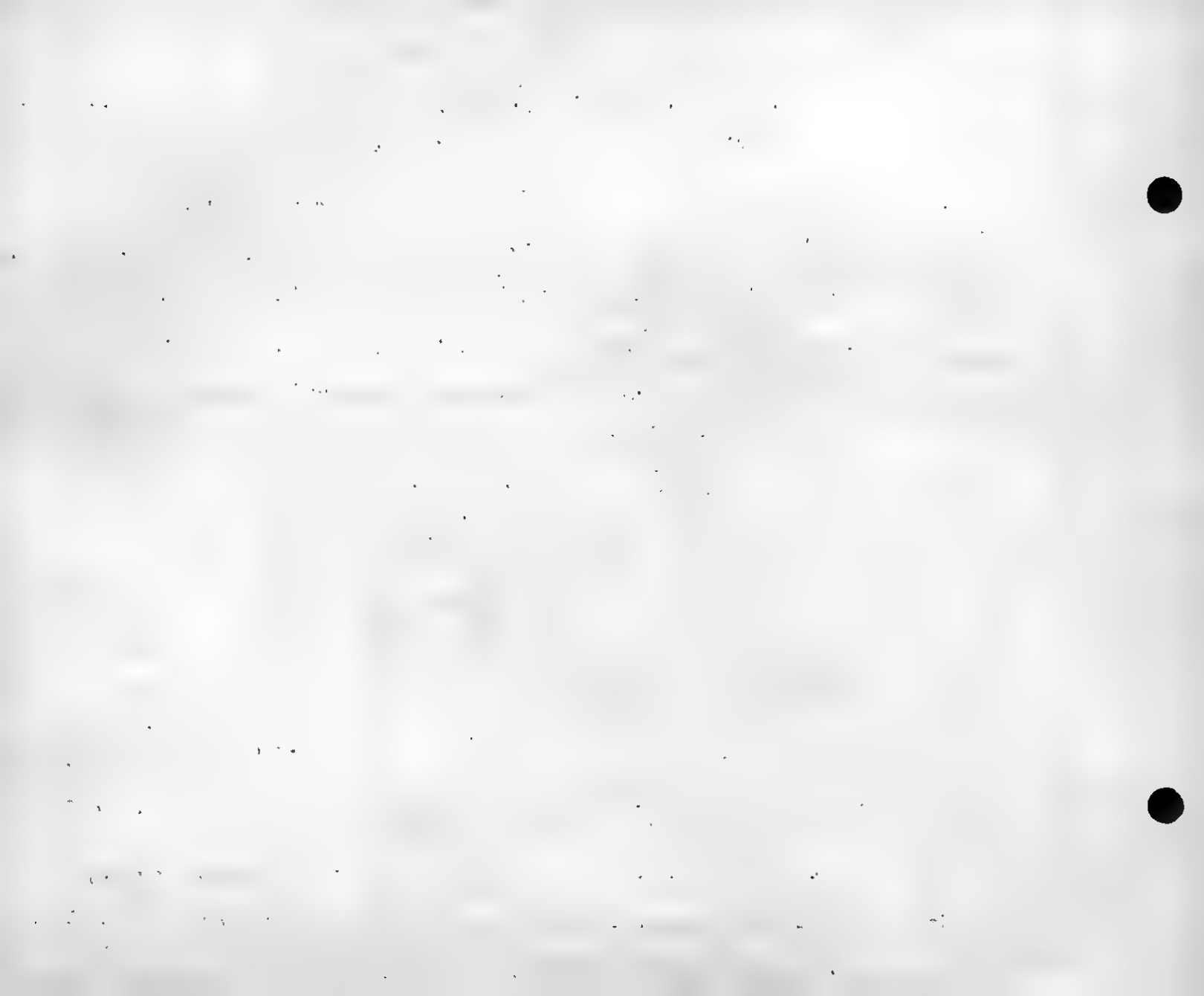


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR 10 30 A.M.	
Warren			Winfield			Jones			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		White		Aug 6, 1902		65 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Washington D.C.		U. S. A.				Prince George Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly, Md.		Prince George		Ret Accountant		Construction Co			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Prince George		W. Hyattsville				6313 Sligo Parkway	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William S. Jones			Rebecca I. Herrald						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No		169-20-1906		CARMEN M. JONES Same as #13 (wife)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Cardiac Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Drugs</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 8-1-1964 to 2-18-1968, that (I) (we) last saw the deceased alive on 2-18-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.									
22b. SIGNATURE A. Deitz, M.D.				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 2-18-68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Aaron Deitz, M.D.				Prince George Plaza Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/21/68		Ft. Lincoln		Colmar Manor P.G.		Md.	
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Hyattsville, Md.				FEB 23 1968		Charles Jones			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										302	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR
John Joseph Kelly Jr.									ESTIMATED <input checked="" type="checkbox"/> 2-25-68 19		noon M
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
Male	White	1-9-1929	39 YRS	MONTHS	DAYS	HOURS	MIN	Month 2 Day 25 Year 68		12:50pm M	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
Maryland		U.S.A.				Prince George's Md.					
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			U.S. Navy Dep't			Engineer		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE				13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland				Prince George		University Park				3410 Penna. Street	
14 FATHER'S NAME				First		Middle		Last		15 MOTHER'S MAIDEN NAME	
John Joseph Kelly										Katherine Hanley	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS		Same as	
						Mrs. Ann E. Kelly		13		a to e	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Gun shot wound of head											
7555 Y DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
a.p. noon			2-25-19 68			Shot self in head at home					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town		
home			home			same as #13			County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town or county)			2-26-68		
John Kehoe M.D. Riverdale, Md.											
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town) (County) (State)			
Burial		2/28/1968		New Cathedral Cemetery				Baltimore, Maryland.			
24 FUNERAL DIRECTOR		ADDRESS				25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE			
Arthur Walters		254 Carroll St, N.W.				DATE		FEE 28 1968			
		Washington, D.C. 20012									



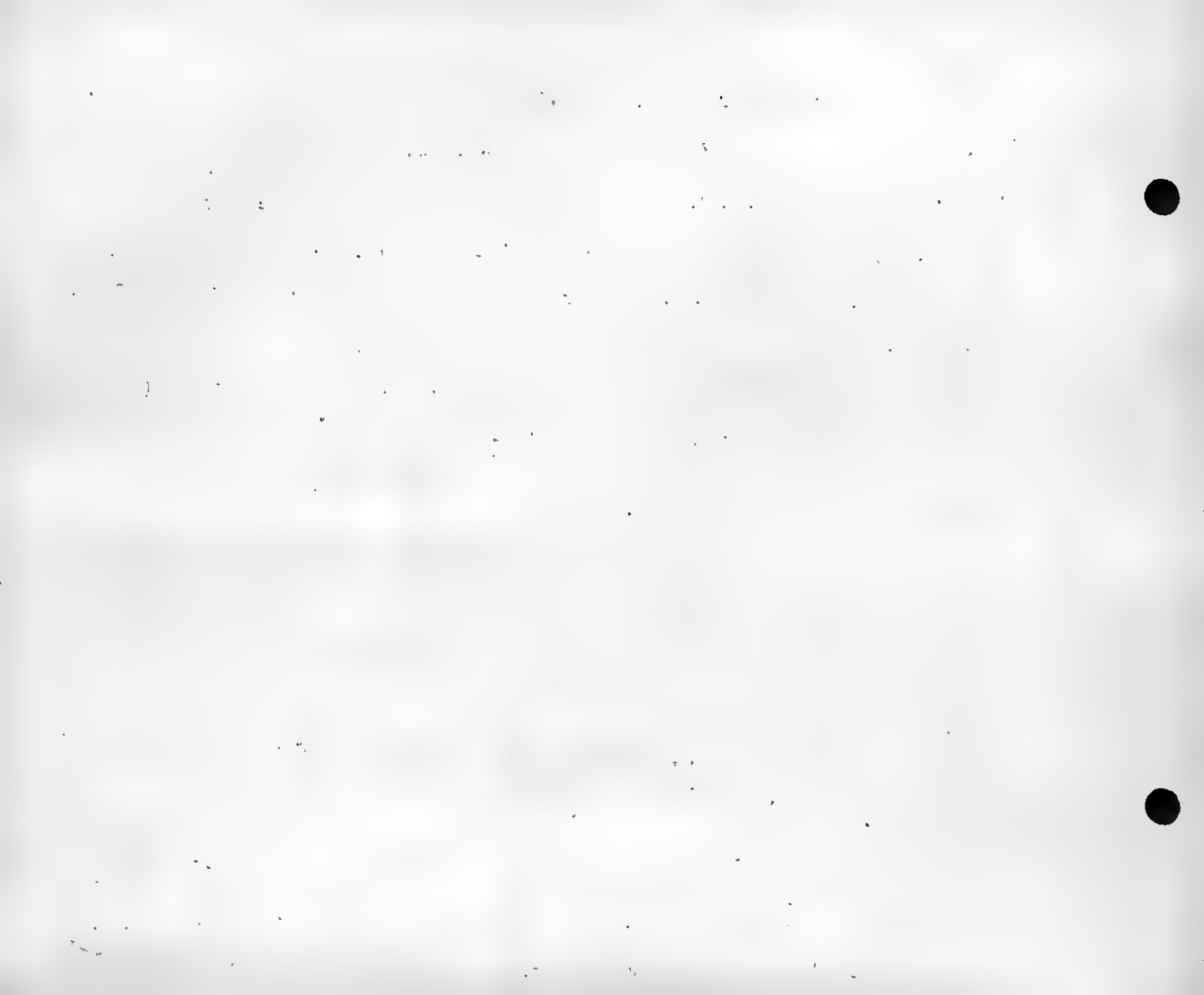
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month <u>2</u> Day <u>11</u> Year <u>1968</u>		2b. HOUR M	
GWENDOLYN		A.		KINCAID				
3. SEX Female		4. RACE White		5. DATE OF BIRTH Oct. 13, 1899		6. AGE (In years lost birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) Kansas		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md		
10. CITY OR TOWN OF DEATH University Park		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 4201 Tuckerman Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home		
13a. USUAL RESIDENCE (Where deceased admission) STATE Md.		13b. COUNTY P.G.		13c. CITY OR TOWN University		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4201 Tuckerman Street
14. FATHER'S NAME John R. Alsop		First	Middle	Last	15. MOTHER'S MAIDEN NAME Emily Jevons		First	Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Calvin B. Kincaid Same as #13 (husband)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Pancreas with Liver</u> <u>1579</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>and lung metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>lost.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.O. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <u>Cecil</u> , 1958 to <u>Feb 11</u> , 1968, that (I) (we) last saw the deceased alive on <u>Jan 17-68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Richard L. Whelton</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-11-68		
22d. PHYSICIAN'S NAME (Type) R. L. Whelton		22e. ADDRESS 1017 University Blvd E						
23a. BURIAL, CREMATION, BURNAL (Specify)		23b. DATE 2/14/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION (City or Town) Colmar Manor P.G.		(County) (State) Md.
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Md.				ADDRESS		25a. REC'D BY REGISTRAR DATE FEB 15 1968		25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>



## CERTIFICATE OF DEATH

3023

1. DECEASED NAME (Type or print) Ann Marilyn Kinch			2a. DATE OF DEATH Feb Month 14 Day 1968 Year			2b. HOUR 6:03 M					
3 SEX Female		4 RACE Caucasian		5. DATE OF BIRTH 20 Aug 1937		6. AGE (In years last birthday) 30 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Rhode Island		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md					
10. CITY OR TOWN OF DEATH Andrews AFB			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Malcolm Grow USAFH			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY n/a		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Rhode Island			13b. COUNTY Providence			13c. CITY OR TOWN Pawtucket		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 57 Chaplin Street	
14. FATHER'S NAME Harold Seymour Firth			15. MOTHER'S MAIDEN NAME Mary D'Olivo								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> no			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT Lawrence W. Kinch			Address 1001 ABWg AAFB Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) malignant melanoma, metastatic 17a7 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 months		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 1999 none											
19a. DATE OF OPERATION none			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED none			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (X) (this hospital) attended the deceased from 13 Dec, 1967, to 14 Feb, 1968, that (X) (we) last saw the deceased alive on 14 Feb 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Joel B. Solomon M.D.						22c. DATE SIGNED 14 Feb 68					
22d. PHYSICIAN'S NAME (Type) JOEL B. SOLOMON, CAPT, USAF MC						22e. ADDRESS MALCOLM GROW USAF HOSP ANDREWS					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE 2/19/68			23c. NAME OF CEMETERY OR CREMATORY Swann Point Cemetery			23d. LOCATION (City or Town) (County) (State) Providence, Rhode Island		
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland, Maryland						25a. REC'D BY REGISTRAR FEB 19 1968			25b. REGISTRAR'S SIGNATURE [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

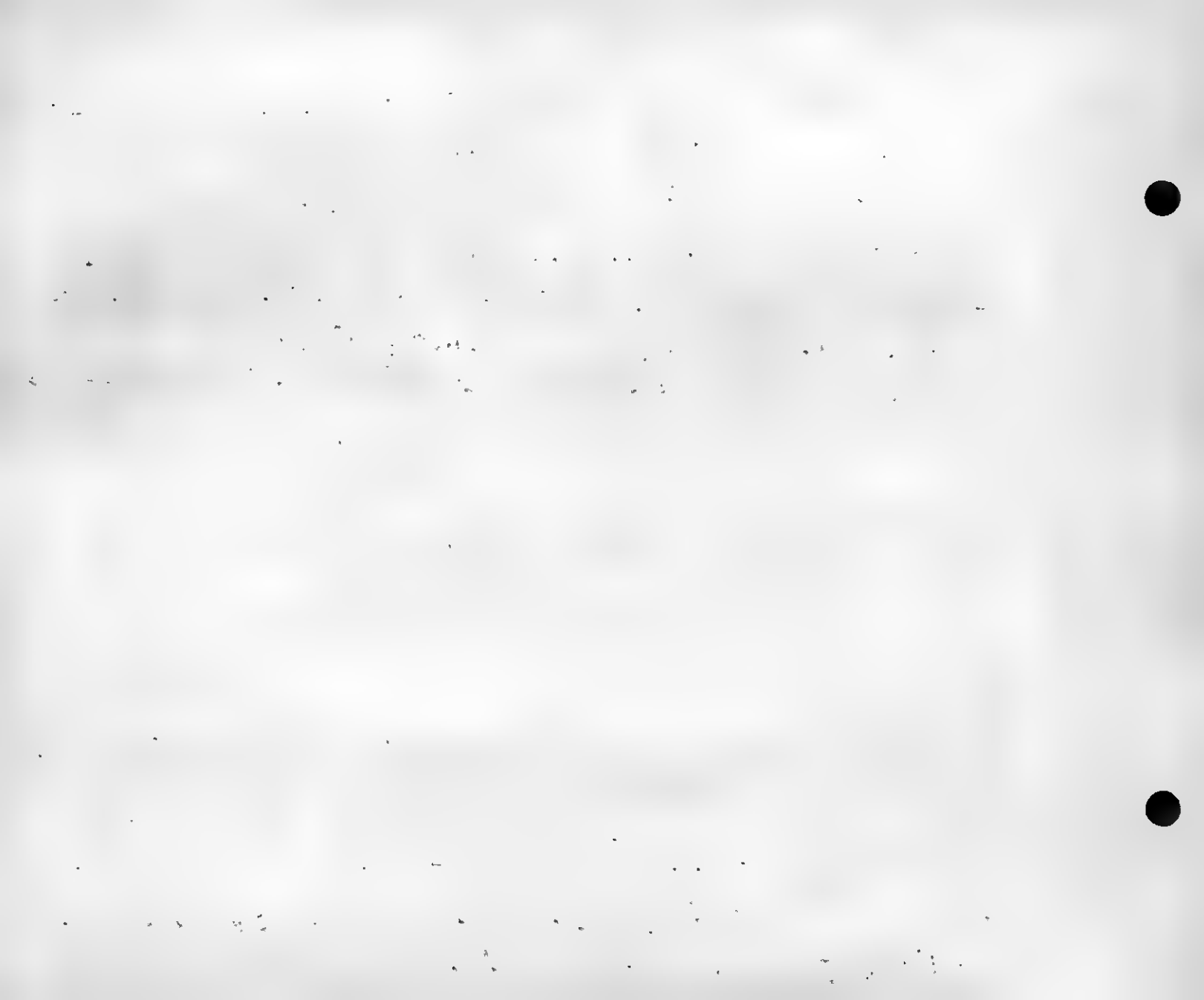




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED NAME (Type or print) <b>Edward</b>			First <b>Edward</b>			Middle <b>U.</b>			Last <b>Kohlbrenner, Sr.</b>			2a. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>1968</b>			2b. HOUR <b>11:30 AM</b>		
3 SEX <b>Male</b>			4 RACE <b>White</b>			5. DATE OF BIRTH <b>7/2/92</b>			6. AGE (In years last birthday) <b>75</b> YRS			IF UNDER 1 YEAR MONTHS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>NEW YORK</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George's</b> Md.								
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) <b>Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Dept of Commerce</b>								
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE <b>Maryland</b> CO. <b>Prince Geo.</b>			13c. CITY OR TOWN <b>Hyattsville</b>			3d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>Madison Manor Nurs Home</b>								
14. FATHER'S NAME First <b>John J.</b> Middle <b>Kohlbrenner</b> Last <b>Kohlbrenner</b>			15. MOTHER'S MAIDEN NAME First <b>Elizabeth</b> Middle <b>Carver</b> Last <b>Carver</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>yes</b> (If yes give war or dates of service) <b>WWI</b>			16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>			17. INFORMANT <b>Edward D. Kohlbrenner</b> Address <b>736 E. Dielovan Av. Buffalo, N.Y.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pneumonia - Pneumonia</b>																	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Anterior stroke 1st time</b>																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>D. cholelithiasis</b>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <b>2-5-1968</b> to <b>2-17-1968</b> , that (I) (we) last saw the deceased alive on <b>2-16-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>Aaron Deitz</b> DEGREE <b>M.D.</b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>												22c. DATE SIGNED <b>2-17-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Aaron Deitz, M.D.</b>												22e. ADDRESS <b>Prince Geo. Plaza, Hyattsville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>21 FEB 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>			23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON, VIRGINIA</b>								
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS</b>			ADDRESS <b>60 RIVERDALE, MD.</b>			25a. REC'D BY REG. STRAR DATE <b>FEB 23 1968</b>			25b. REG. STRAR'S SIGNATURE <b>Charles Judge</b>								

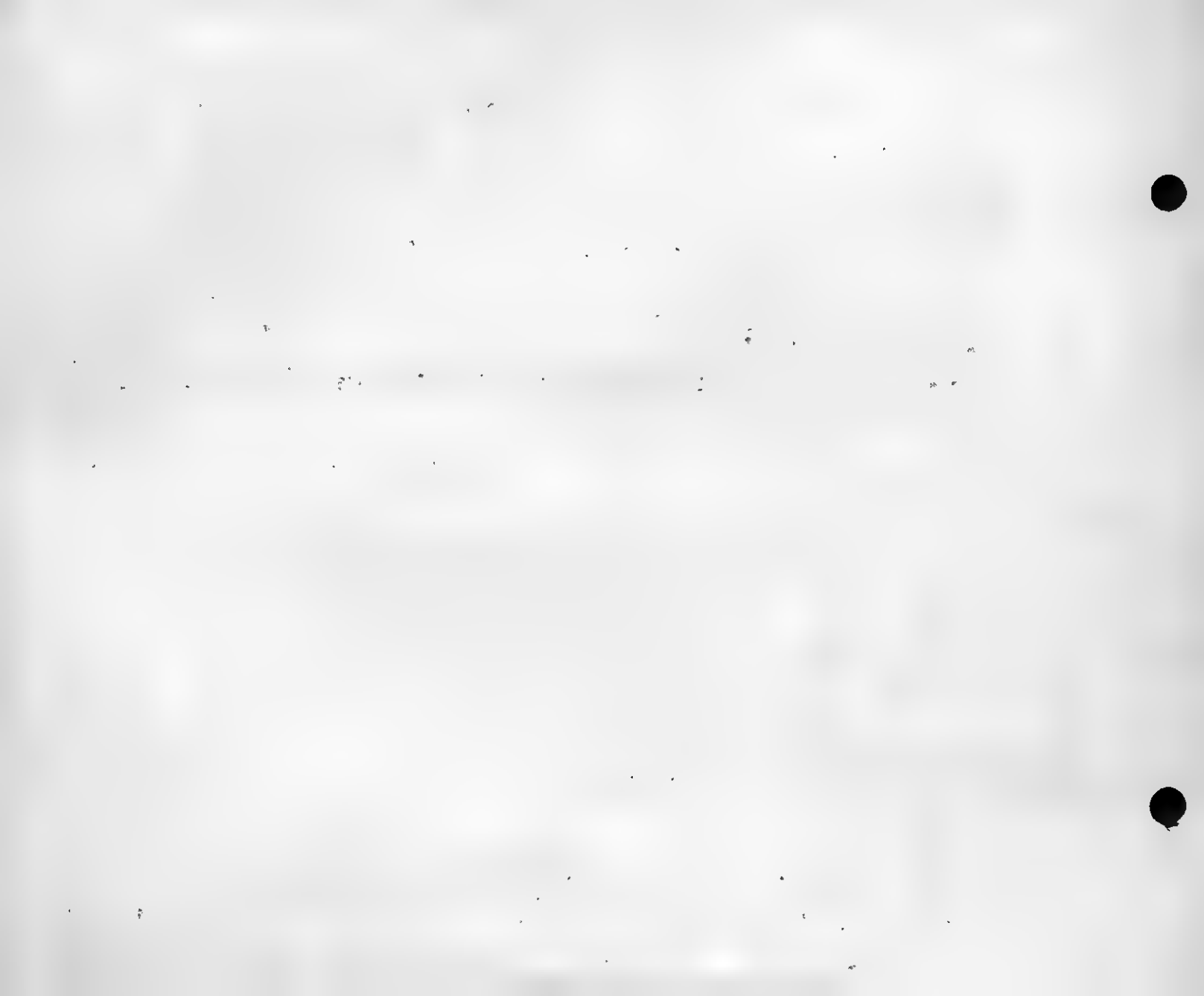


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, or any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH	
Loretta		J.		LADD		LADD		<input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2-14-68 10:27 PM	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 MONTHS	8 DAYS	9 HOURS	10 MIN.	2c DATE PRONOUNCED DEAD	2d HOUR
Female	White	8 July 1897	70 YRS					2 Month 14 Day 68 Year 10:27 PM	
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
NEW YORK	U.S.			Prince George's Md					
10 CITY OR TOWN OF DEATH		NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George Hospital				HOUSEKEEPER			
13a USUAL RESIDENCE (Where deceased lived, if not institution)		13b CITY OR TOWN		13c INSIDE CITY LIMITS?		13e STREET AND NUMBER			
Maryland		Riverdale		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		5422 56th. Avenue			
14 FATHER'S NAME		15 MOTHER'S MAIDEN NAME							
ABRAHAM MA GALE		MARIE MAKINS							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT					
No		220462583		ROBERT NELSON LADD JR. BAC ADDRESS USA COM ZEP, STAM PICO APO NY 09058					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure									over 1 hour
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease									unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21a TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		19 P.M.							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b DATE SIGNED	
EXAMINER'S NAME (Type)		John Kehoe MD		Riverdale, Md.		2-15-68			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
Cremation		20 Feb 1968		Fort Lincoln Cem.		FOLMAR MANOR MD			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE			
W.W. CHAMBERS GO.		RIVERDALE, MD.		DATE FEB 21 1968		J. Charles Jones			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>RUTH E. LAFRENIERE</b>			2a. DATE OF DEATH <b>FEB</b> Month <b>28</b> Day <b>1968</b> Year			2b. HOUR <b>2200</b> M			
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH <b>10 OCT 1945</b>		6. AGE (in years last birthday) <b>22</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>WASH DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>PRINCE GEORGE</b> Md.			
10. CITY OR TOWN OF DEATH <b>ANDREWS AFB</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>MALCOLM GROW USAF</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>CLERICAL</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US NAVY</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institut on- Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>PRINCE GEO.</b>		13c. CITY OR TOWN <b>RIVERDALE</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <b>6005 67th AVE.</b>	
14. FATHER'S NAME First Middle Last <b>OLIVER ZILER NOLAND</b>				15. MOTHER'S MA DEN NAME First Middle Last <b>VERA LYONS</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>DONALD E. NOLAND BROTHER</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>MASSIVE HEMORRHAGE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>THROMBOCYTOPENIC PURPURA</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>24 hr</b> <b>3 weeks</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <b>27 Jan 68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CEASAREAN SECTION</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>27 FEB, 1968</b> , to <b>28 FEB, 1968</b> , that (I) (we) last saw the deceased alive on <b>28 FEB 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Leonard R. Farber</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>28 FEB 68</b>			
22d. PHYSICIAN'S NAME (Type) <b>LEONARD R. FARBER CAPT USAF</b>				22e. ADDRESS <b>MALCOLM GROW USAF HOSP ANDREWS</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 4, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington Virginia</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>		ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>MAR 6 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



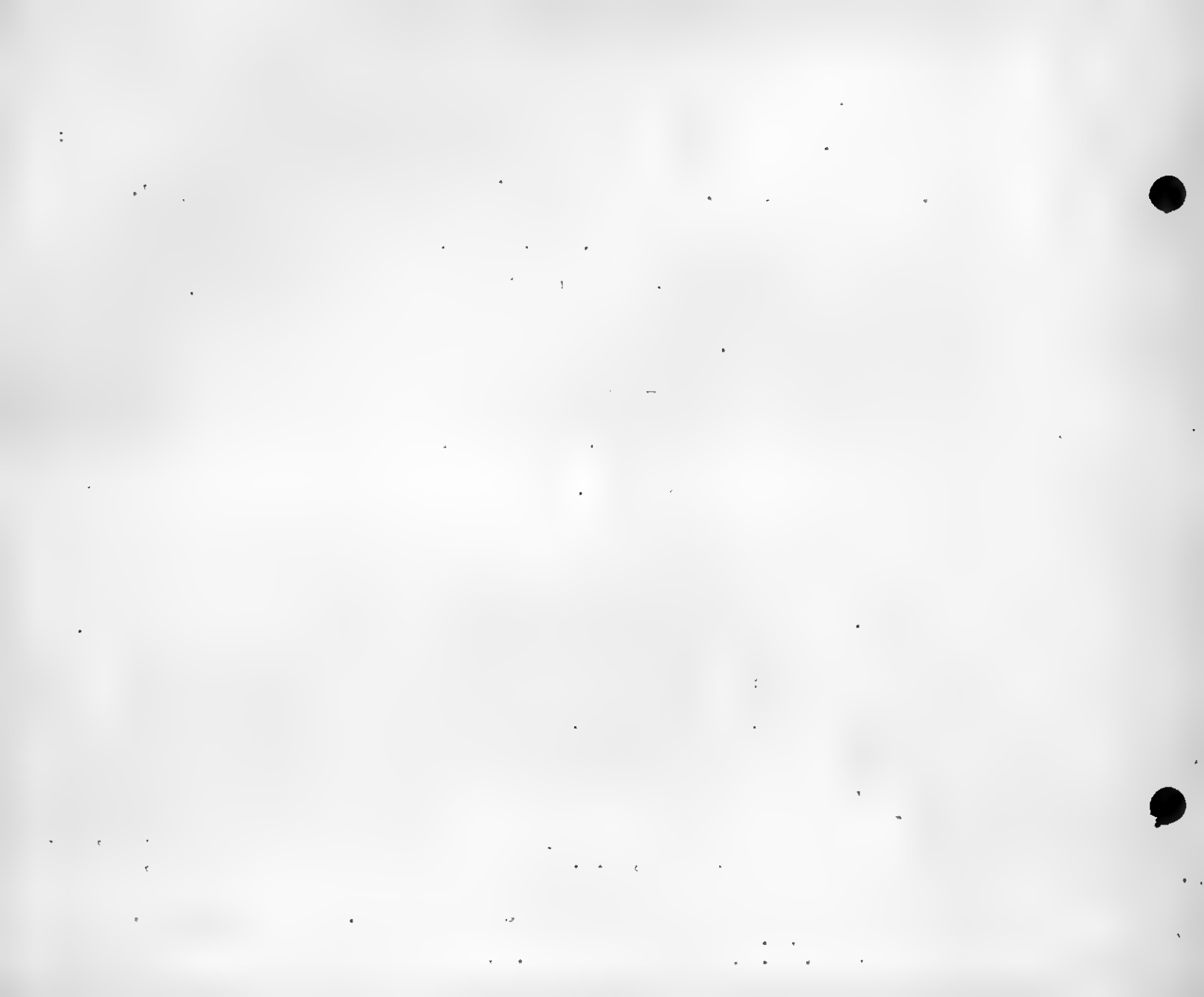
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

1 DECEASED NAME (Type or Print) <b>Francis J. Landis</b>			2a DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> <b>2-16-68</b> 19 <b>AM</b>		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>11-9-06</b>	6 AGE (in years last birthday) <b>61</b> YRS	7 MONTHS <b>11</b>	8 DAYS <b>16</b>
7a BIRTHPLACE (State or foreign country) <b>Wash. D.C.</b>		7b CITIZEN OF <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Prince George's</b> Md.	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen. Hospt.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Salesman</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Prince George's</b>		13c STREET AND NUMBER <b>204 Audrey Lane</b>	
14 FATHER'S NAME First Middle Last <b>George M. Landis</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Shugrue</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <b>yes</b>		16b SOCIAL SECURITY NO <b>577-10-7678</b>		17. INFORMANT <b>Wife</b> ADDRESS <b>Same as above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive trauma to head.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Automobile accident.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>3 days</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>2254</b>					
19a DATE OF OPERATION <b>None</b>		19b CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b>		20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year <b>5:30 P.M. 2-12-68</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Automobile accident</b>	
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Rt. 450 &amp; 50, jtc. 495</b>		21f. LOCATION Street or R.F.D. No City or Town County State	
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Cornelius J. Burns</b>		M.D. <b>Acting</b>		22b DATE SIGNED <b>Feb. 16, 1968</b>	
EXAMINER'S NAME (Type) <b>Cornelius J. Burns, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <b>Cheverly, Maryland</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b DATE <b>2/20/68</b>	23c NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cem. Baltimore, Md.</b>		23d LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>The S.H. Hines Company</b> <b>2901 14th St. N.W. Washington, D.C.</b>		25a REC'D BY REGISTRAR <b>FEB 19 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



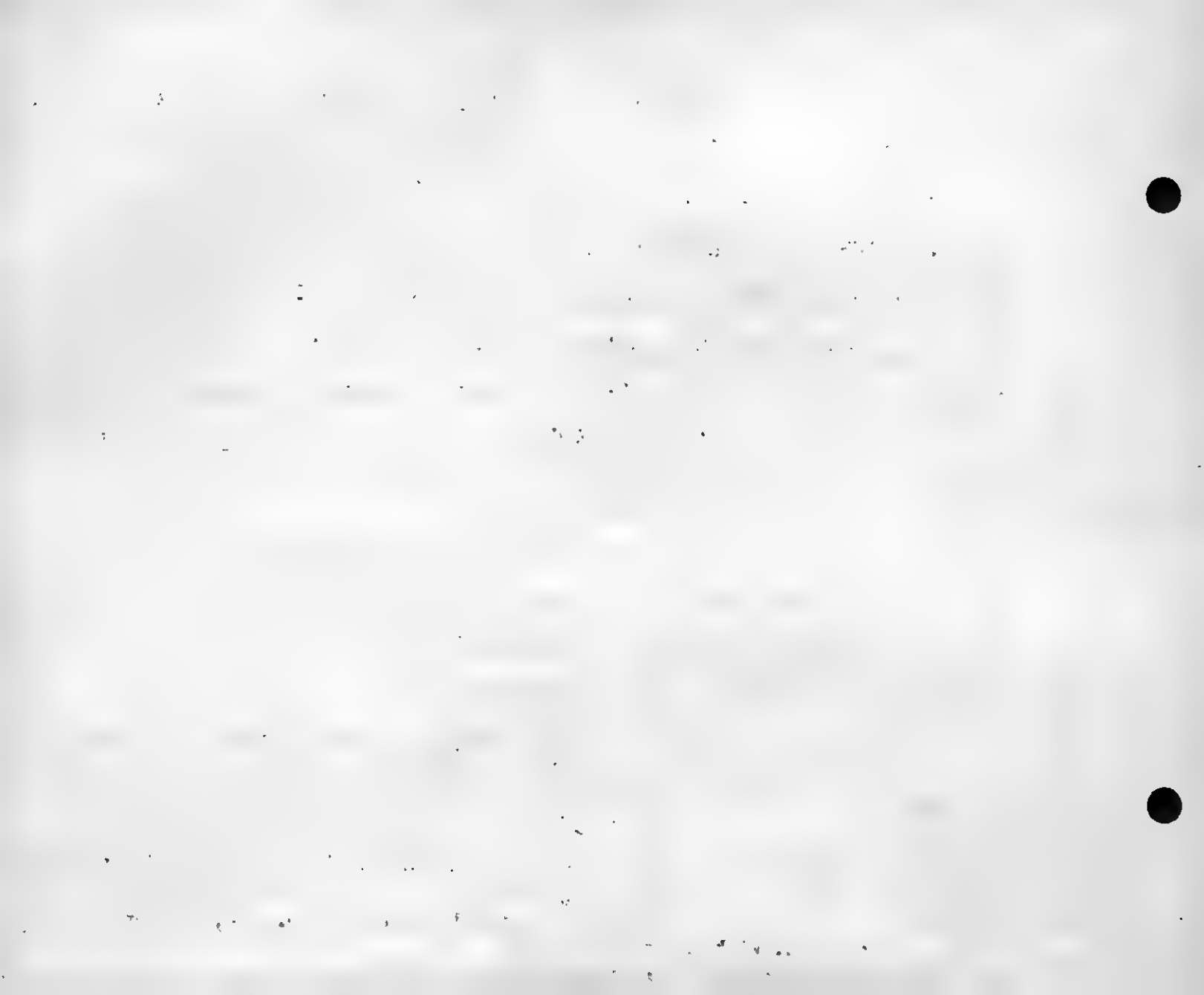


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print) First Middle Last <b>TIFFANY DENESE LANDIS</b>						2a DATE OF DEATH Feb Month 5 Day 68 Year			2b HOUR P 1:35M				
3. SEX <b>FEMALE</b>		4 RACE <b>CAUC</b>		5. DATE OF BIRTH <b>3 Feb 68</b>			6 AGE (In years lost birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George</b> Md.						
10. CITY OR TOWN OF DEATH <b>Andrews AFB</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Malcolm Grow USAFH</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>n/a</b>			12b KIND OF BUSINESS OR INDUSTRY <b>n/a</b>				
13a USUAL RESIDENCE (Where deceased admission) STATE <b>Maryland</b>			13b COUNTY <b>Prince George</b>			13c CITY OR TOWN <b>Forestville</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER <b>7313 Keyston Lane</b>	
14 FATHER'S NAME First Middle Last <b>CALVIN LOUIS LANDIS</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>MARY FLORENCE BURGE</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b SOCIAL SECURITY NO. <b>n/a</b>			17. INFORMANT Address <b>Father same as item #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>777X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs.</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>D716</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f LOCATION Street or R.F.D. No. City or Town County State							
22a I certify that (I) (this hospital) attended the deceased from <b>3 Feb</b> , 19 <b>68</b> , to <b>5 Feb</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5 Feb</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, ( <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.													
22b SIGNATURE <b>William E. Palma, Capt USAF</b> DEGREE						ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>5 FEB 68</b>				
22d. PHYSICIAN'S NAME (Type) <b>WILLIAM E. PALMA, CAPT</b>						22e ADDRESS <b>MALCOLM GROW USAF HOSP ANDREWS AFB</b>							
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b DATE <b>2/8/68</b>			23c NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>			23d LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>				
24 FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>						25a REC'D BY REGISTRAR <b>FEB 13 1968</b>			25b. REGISTRAR'S SIGNATURE				



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED NAME (Type or Print) <b>Clarence Levi Lee</b>			2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 2-21-68 19 5			2b HOUR 00am						
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>7-3-1887</b>	6 AGE (In years last birthday) <b>80</b> YRS.	IF UNDER 1 YEAR MONTHS <b>2</b>	IF UNDER 24 HRS. DAYS <b>21</b>	7c DATE PRONOUNCED DEAD Month <b>2</b>	Day <b>21</b>	Year <b>68</b> 19 11	2d HOUR 00am			
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b>			Mid			
10 CITY OR TOWN OF DEATH <b>Riverdale</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Chamber's Funeral Home</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>FARM LABORER</b>			12b KIND OF BUSINESS OR INDUSTRY <b>FARM</b>				
13a U.S.A. RESIDENCE (Where deceased lived, if not last on. Residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Prince George's</b>		13c CITY OR TOWN <b>Mitchellville</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>RFD #2</b>			
14 FATHER'S NAME First <b>LEVI T.</b> Middle <b>LEE</b> Last <b>LEE</b>			15 MOTHER'S MAIDEN NAME First <b>ANNIE E.</b> Middle <b>HAINES</b> Last <b>HAINES</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b SOCIAL SECURITY NO. <b>NONE</b>			
17 INFORMANT <b>NEPHEW</b>			18 ADDRESS <b>NEW WINDSOR, MD.</b>			19 NAME <b>WALTER T. LEE</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Heart failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b> <b>unknown</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No.			City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>John Kehoe</b>			EXAMINER'S NAME (Type) <b>John Kehoe, MD</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>2-22-68</b>			
23a BURIAL CREMATION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/>			23b DATE <b>FEB. 25/68</b>			23c NAME OF CEMETERY OR CREMATORY <b>SAM'S CREEK CEM.</b>			23d LOCATION (City or Town) (County) (State) <b>MARSTON, CARROLL, MD.</b>			
24 FUNERAL DIRECTOR <b>Anna G. Saffell</b>			25 ADDRESS <b>254 WESTMINSTER, MD</b>			25a. REC'D BY REGISTRAR <b>FEB 26 1968</b>			25b. REGISTRAR'S SIGNATURE <b>John Kehoe</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Sadie Leeks</b>			2a. DATE OF DEATH <b>Feb. 16, 1968</b>			2b. HOUR <b>4 A. M.</b>						
3. SEX <b>Female</b>		4. RACE <b>Negroid</b>		5. DATE OF BIRTH <b>12/12/01</b>		6. AGE (In years last birthday) <b>67</b>		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b>						
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>				12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUA. RESIDENCE (Where deceased admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Chapel Oak</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1204 57th Ave.</b>				
14. FATHER'S NAME <b>Unknown</b>			15. MOTHER'S MAIDEN NAME <b>Unknown</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT <b>Leroy W. Carter 4329 Chaplin Street, S.E.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage, Rt. Hemisphere</b> <b>4 - - -</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Essential Hypertension</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State								
22a. I certify that (this hospital) attended the deceased from <b>Feb. 6, 1968</b> to <b>Feb. 16, 1968</b> , that (we) last saw the deceased alive on <b>FEB. 16, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (we) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>R. Franchi</b>				22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type) <b>Riccardo U. Franchi, M. D.</b>				
22e. ADDRESS <b>Prince Georges General Hospital</b>												
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>2/20/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>						
24. FUNERAL DIRECTOR <b>M. E. Ernest Jarvis Co., 1432 1st Street, N.W.</b>				25a. REC'D BY REGISTRAR <b>FEB 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles James</b>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

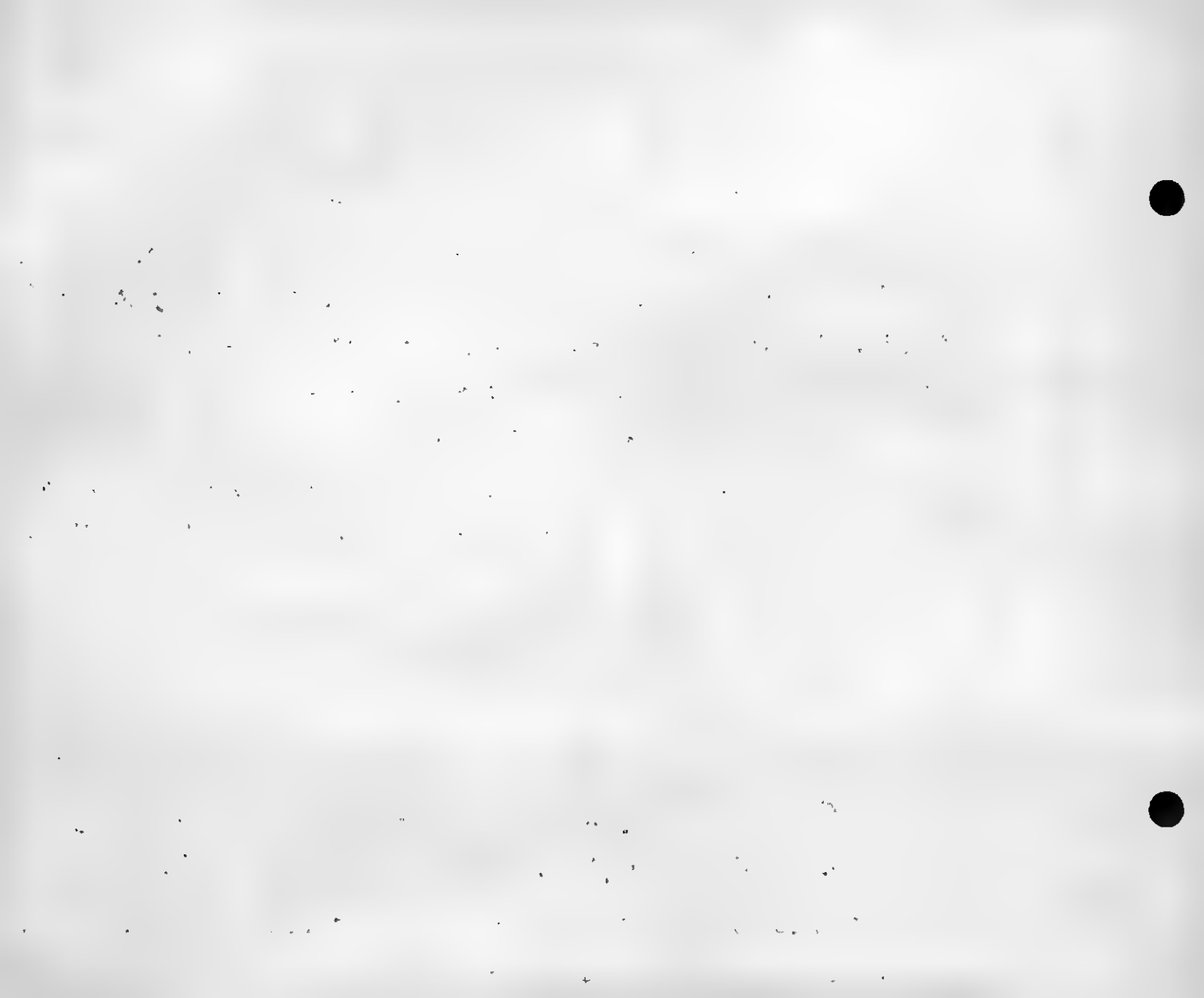
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**CERTIFICATE OF DEATH**

3031

1. DECEASED-NAME (Type or print) <b>AGNES M LONG</b>			2a. DATE OF DEATH Month <b>2</b> Day <b>11</b> Year <b>68</b>		2b. HOUR <b>4:59</b> P.M.
3. SEX <b>Female</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH <b>2-5-1877</b>		6. AGE (In years last birthday) <b>90</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>PRINCE GEORGES County, Md.</b>		
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hyattsville Nursing Home</b>	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>OWN Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Prince George</b>	13c. CITY OR TOWN <b>Bowie</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>6204 Alexis DR.</b>	
14. FATHER'S NAME First <b>Michael</b> Middle <b>H</b> Last <b>Dougherty</b>	15. MOTHER'S MAIDEN NAME First <b>Journea</b> Middle <b>MacDonald</b> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b> (If yes give war or dates of service)	16b. SOCIAL SECURITY NO <b>578-34-9754</b>	17. INFORMANT <b>FERNAN J LONG Same as #13 SON</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MYOCARDIAL FAILURE</b> <b>129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE, OLD INFARCT</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>GENERALIZED ARTERIO SCLEROSIS-SENILITY</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 MONTHS</b> <b>2 YEARS</b> <b>10 YEARS</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (At home, farm, street, factory, office building etc)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>DECEMBER 1967</b> to <b>LIFE</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2-8-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John Cosma M.D.</b>		DEGREE	ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>2-11-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>JOHN COSMA, M.D.</b>		22e. ADDRESS <b>3233 SUPERIOR LA, Bowie, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2/13/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland P.G. Md.</b>	
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>			25a. REC'D BY REGISTRAR <b>DATE FEB 13 1968</b>	25b. REGISTRAR'S SIGNATURE	

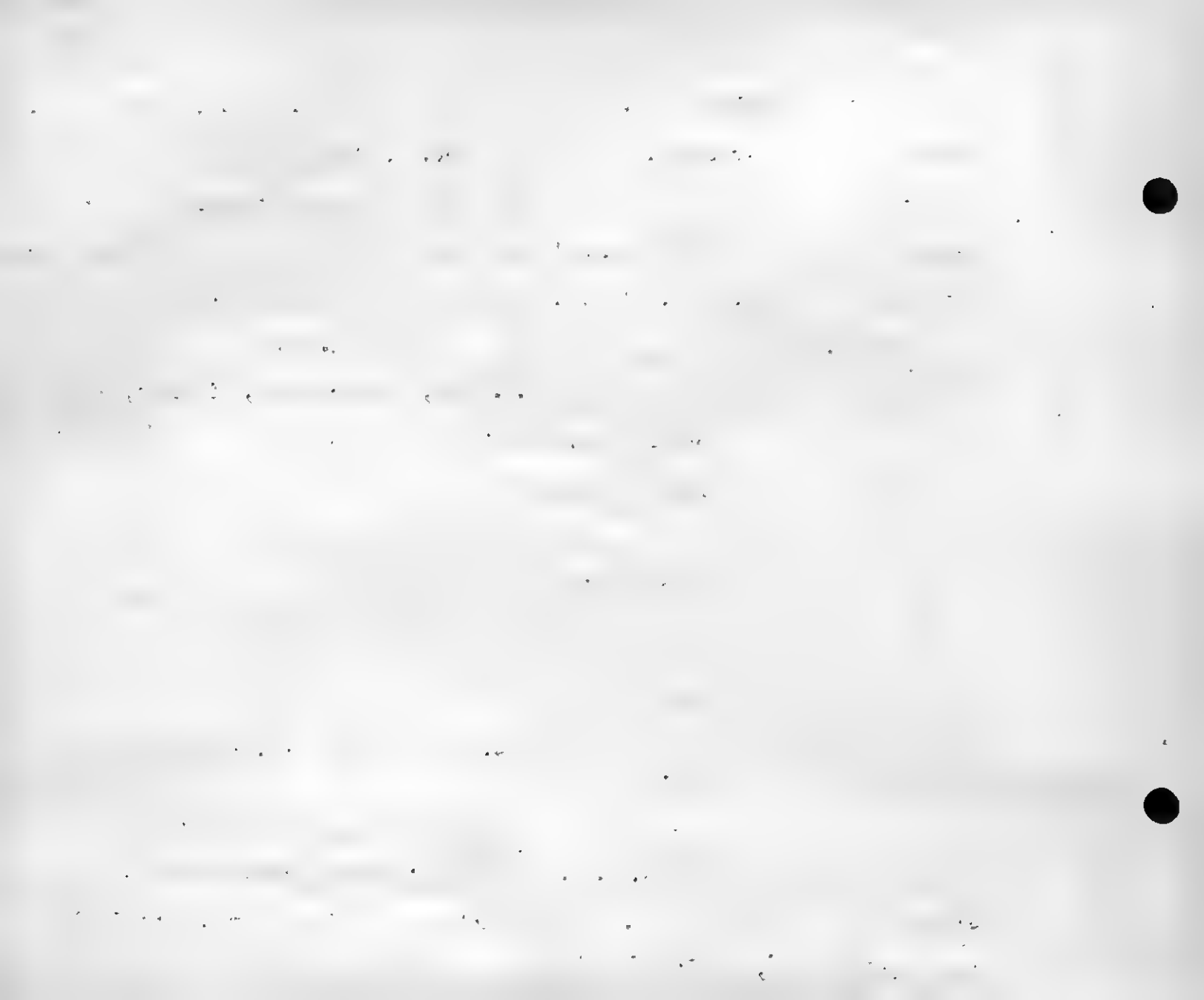




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03046		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				3032					
Item 6 Film G398 2/28/68 kk		CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)		First		Middle		Last		2a DATE OF DEATH		2b HOUR	
Lewis		W.		Long		Feb.		Month 15, Day 1968		7 A. M.	
3. SEX		4 RACE		5 DATE OF BIRTH		6 AGE (in years last birthday)		7 UNDER 1 YEAR		7 UNDER 24 HRS.	
Male		Caucasian		Dec. 2, 1913		33 54 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		USA				Prince Georges Md					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince Geo. Gen'l Hospital		Painter		Construction					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland		Prince Geo. G		Mt. Rainier				108 64th Place			
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Fred F. Long								Susie P Waller			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17 INFORMANT		Address					
				J.M. Long		1130 49th Ave, Hillside, Maryland					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Tracheobronchitis</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Bronchopneumonia</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)											
<u>Diabetes Mellitis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that <del>the</del> (this hospital) attended the deceased from <u>Dec. 27, 1967</u> , to <u>Feb. 15, 1968</u> , that <del>he</del> (we) last saw the deceased alive on <u>Feb. 15, 1968</u> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22g. REGISTRAR'S SIGNATURE	
		2/10/68		William Holbrook, M. D.		Prince Georges General Hospital					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		2/19/68		Ft. Lincoln Cemetery		Prince Georges, Maryland					
24. FUNERAL DIRECTOR		Address		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Robert E. Wilhelm		Funeral Home		FEB 19 1968		Charles J. Judge					
4308 Suitland Road, Suitland, Maryland											



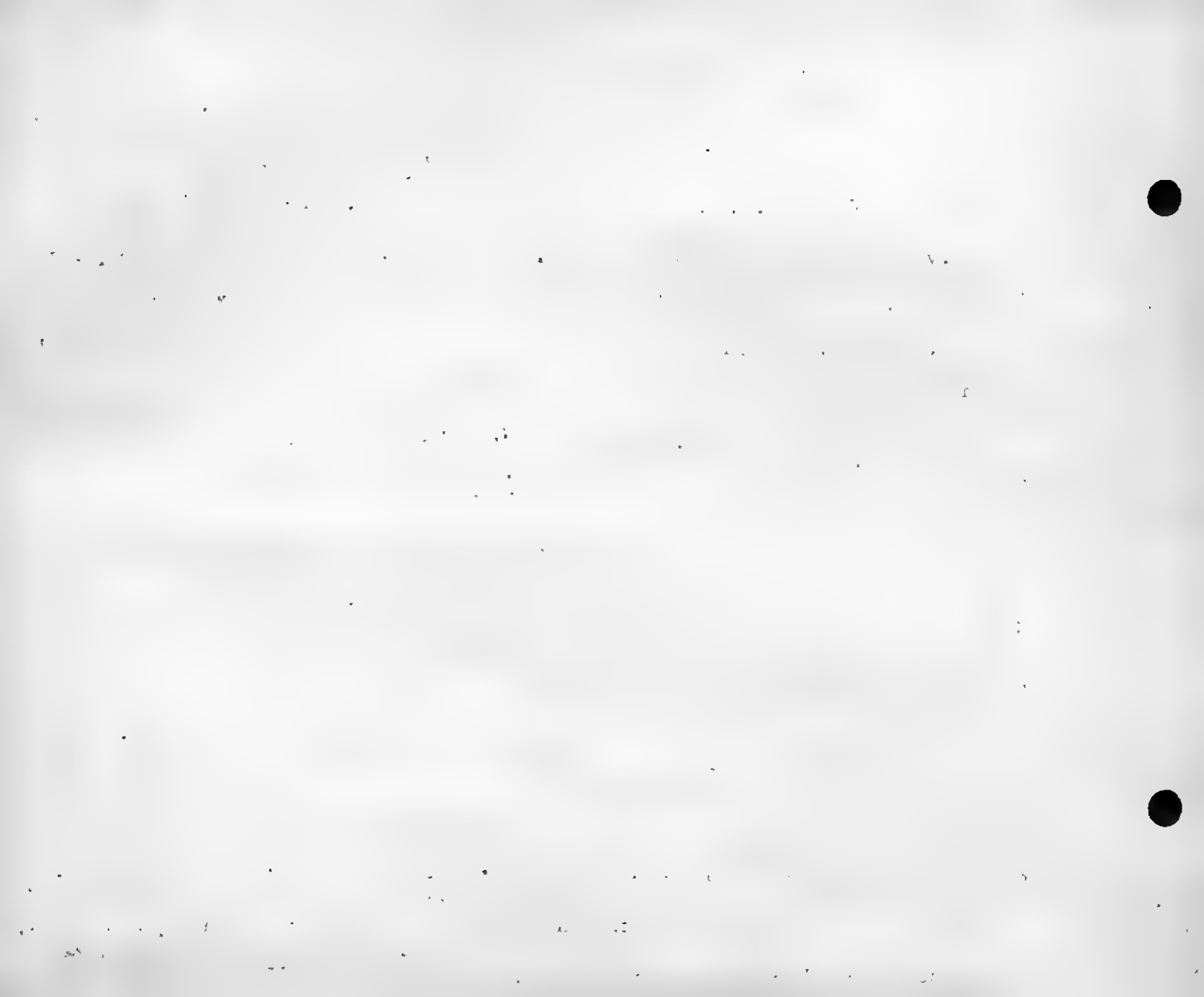
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Medical examiner notified & Approved

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <b>VERA</b>					First Middle Last		2a. DATE OF DEATH Month Day Year		2b. HOUR
					<b>LUPTON</b>		<b>FEBRUARY 12 1968</b>		<b>12:30 PM</b>
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>July 11, 1908</b>		6 AGE (In years last birthday) <b>59</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George</b> Md.			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Nurse</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
13a. USJA RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Md.</b>			13b COUNTY <b>Prince George</b>			13c CITY OR TOWN <b>Bladensburg</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>4919 Newton Street</b>									
14. FATHER'S NAME <b>Joseph L. Lupton</b>					15 MOTHER'S MAIDEN NAME <b>Swinson</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17. INFORMANT <b>Hospital Records</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> <b>4 years</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4 years</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>7-9, 1967</b> to <b>2-12, 1968</b> , that (I) (we) last saw the deceased alive on <b>2-11, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>A Deitz</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-12-68</b>			
22d PHYSICIAN'S NAME (Type) <b>Aaron Deitz, M. D.</b>		22e ADDRESS <b>Prince George Plaza Cheverly, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/14/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>			
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>				ADDRESS		25a REC'D BY REGISTRAR <b>FEB 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



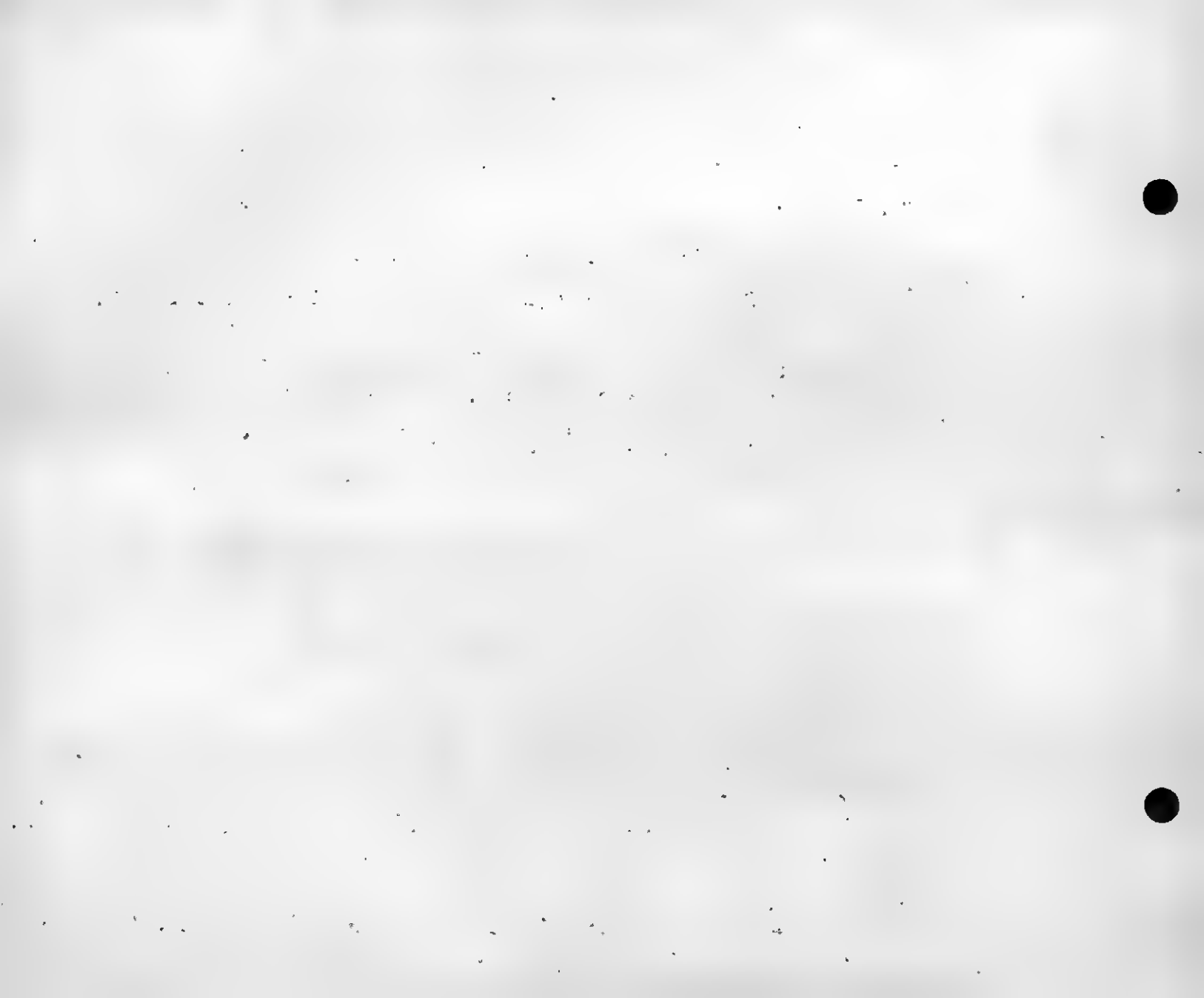
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VR A15 (4-5)  
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

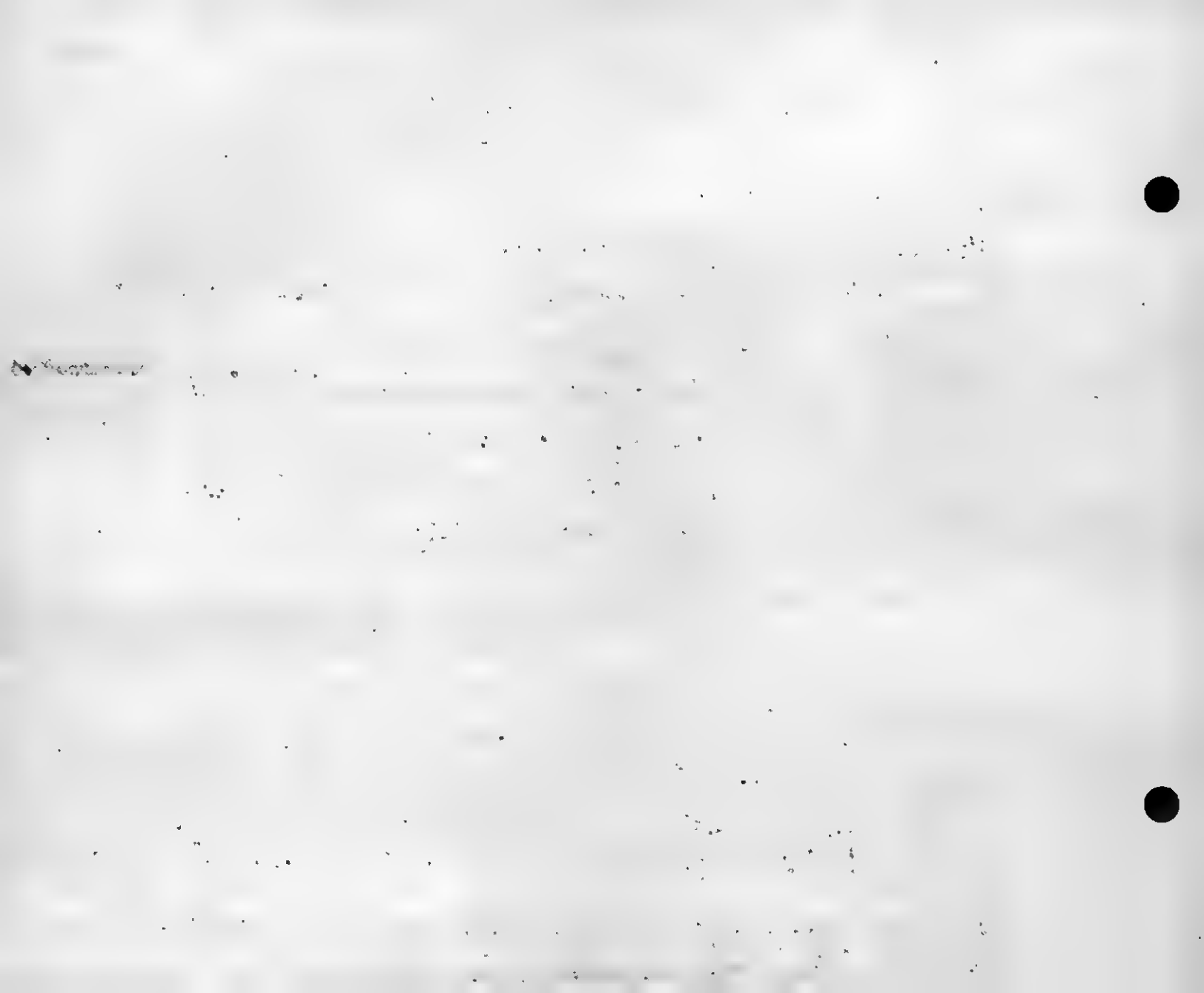
1. DECEASED-NAME (Type or print) First Middle Last Elvin M Luskey			2a. DATE OF DEATH Month Day Year 02 28 68			2b. HOUR 5:20 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 1916-11-25		6. AGE (In years last birthday) 51 YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Wash. DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.			
10. CITY OR TOWN OF DEATH Riverdale		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Leland Memorial		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Engineer		12b. KIND OF BUSINESS OR INDUSTRY Fed Govt			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Md		13b. COUNTY PG		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4600 Sheridan St.	
14. FATHER'S NAME First Middle Last Elvin M Luskey			15. MOTHER'S MAIDEN NAME First Middle Last Lanham, Alice						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO 277-18-3841		17. INFORMANT Mary Jeanne Luskey		Address s/a			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE CORONARY OCCLUSION if 1/2... DUE TO, OR AS A CONSEQUENCE OF ART. SCL. CORONARY ARTERY DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE 1 MONTH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 5 FEB, 1968, to 26 FEB, 1968, that (I) (we) lost the deceased alive on 25 FEB, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE C. J. Houmann		DEGREE M.D.		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 25 FEB '68			
22d. PHYSICIAN'S NAME (Type) C. J. HOUMANN		M.D.		22e. ADDRESS RIVERDALE		MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3/1/1968		23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City or Town) Linthicum		(County) (State) Prince Georges Md	
24. FUNERAL DIRECTOR M. J. M. J.		ADDRESS 131-11 1st St. S.E.D.C.		25a. REC'D BY REGISTRAR DATE FEB 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <b>Angus</b> First <b>Angus</b> Middle <b>Delbert Mac</b> Last <b>Donald</b>						2a. DATE OF DEATH Month <b>2</b> Day <b>6</b> Year <b>68</b>			2b. HOUR <b>9:20</b> M		
3. SEX <b>male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>7/5/1891</b>		6. AGE (in years last birthday) <b>76</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Michigan</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.					
10. CITY OR TOWN OF DEATH <b>Hyattsville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Hyattsville Nursing Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Veterinarian</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>MECHANICAL</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>College Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>4002 Metzgerott Rd.</b>		
14. FATHER'S NAME First <b>Archie</b> Middle <b>J.</b> Last <b>Mac Donald</b>				15. MOTHER'S MAIDEN NAME First <b>Amelia</b> Middle <b>Jane</b> Last <b>Frank</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>220-44-4002</b>		17. INFORMANT <b>MRS. Jane Rankin - Adelphi - Md</b> Address <b>2113 Rolander ST. - Adelphi - Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cerebral Dioxine</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic malignant brain tumor</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>glioblastoma of brain</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>1 mo.</b> <b>6 mo.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b></b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>							
22a. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>Aug. 1, 1967</b> to <b>2-6, 1968</b> , that <b>(1)</b> (we) last saw the deceased alive on <b>2-5, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>R.D. Bauer, M.D.</b>				DEGREE <b></b> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-6-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>R.D. Bauer, M.D.</b>				22e. ADDRESS <b>2513 Bulk Lodge Rd. Adelphi, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE <b>Feb. 8, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>West Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Maryland</b>					
24. FUNERAL DIRECTOR <b>Glenn Carter</b>		ADDRESS <b>8434 Georgia Ave.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John Judge</b>					
26. ANNEX <b>annex E. Pumphrey, Inc.</b>		ADDRESS <b>Silver Spring, Md.</b>									





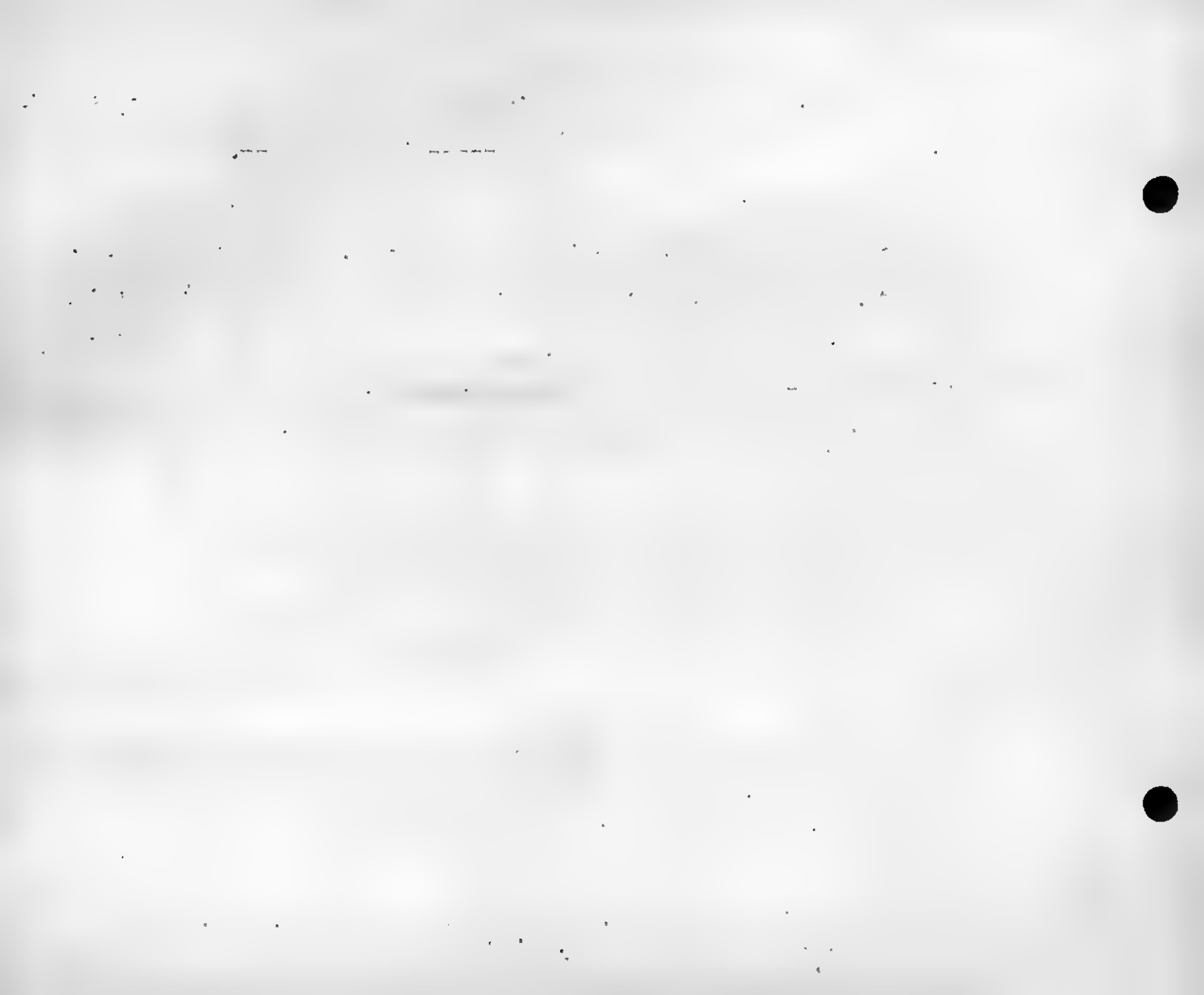
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR		
Mary				Marsden	February 9, 1968		9:37 AM		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR	
Female		White		8-4-77		90-92 YRS		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		USA				Prince Georges			Md.
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Riverdale		Eugene Leland Memorial		Ret. U.S. Treasury Dept.					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.		Prince Georges		Hyattsville				2400 Queens Chapel Road	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
Daniel				Geary	Mary				O'Brien
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		(If yes give year or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT Address			
NO						Medical Record			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>ACUTE PNEUMONITIS</u> <u>486 X</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 WEEKS</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>GEN. ARTERIOSCLEROSIS</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>12-26</u> , 19 <u>67</u> , to <u>9 FEB</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>9 FEB</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>C. J. Houmann M.D.</u>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>9 FEB 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>C. J. HOUMANN</u>		22e. ADDRESS <u>RIVERDALE MD</u>							
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>2/12/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Wash., D.C.</u>			
24 FUNERAL DIRECTOR <u>Malley's Funeral Home Inc.</u>		ADDRESS <u>Mt. Rainier Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 13 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. ...</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

03051

2031

1 DECEASED-NAME (Type or print) <b>CARRIE M MARSH</b>			2a. DATE OF DEATH Feb Month 21 Day 1968 Year			2b. HOUR 7:45 PM				
3 SEX <b>FEMALE</b>		4 RACE <b>NEGRO</b>		5. DATE OF BIRTH <b>MARCH 24, 1901</b>		6 AGE (In years last birthday) <b>66</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>PRINCE GEORGES Md</b>				
10. CITY OR TOWN OF DEATH <b>CHEVERLY</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>PRINCE GEORGES COUNTY</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>			13b COUNTY <b>PRINCE GEORGES</b>			13c CITY OR TOWN <b>FARMINGTON</b>			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e STREET AND NUMBER <b>905 EASTERN AVENUE</b>			14. FATHER'S NAME First Middle Last <b>Richard Steele</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>Lucy McWhorter</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO. <b>243-14-7309</b>			17 INFORMANT <b>Isaac Marsh (Nephew)</b>			Address <b>905 Eastern Ave. N.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>UREMIA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic glomerulonephritis (chronic)</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b> <b>don't know</b> <b>4 years</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Fracture of humerus</b> <b>Cirrhosis of liver</b> , <b>Arteriosclerotic heart disease</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 1967, to <b>Feb 22</b> , 1968, that (I) (we) last saw the deceased alive on <b>21 Feb</b> 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Ronald P. Hairston M.D.</b>						22c. DATE SIGNED <b>22 Feb 1968</b>			22d. PHYSICIAN'S NAME (Type) <b>RONALD P. HAIRSTON</b>	
22e. ADDRESS <b>3302 HAYES ST GLENDALE, MD</b>										
23a (BURIAL, CREMATION, REMOVAL) (Specify)			23b. DATE <b>2-29-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Family Plot</b>			23d. LOCATION (City or Town) (County) (State) <b>Charlotte N.C.</b>	
24. FUNERAL DIRECTOR <b>Partners Funeral Home</b>			ADDRESS <b>3831-7a, Ave. Wash., D.C.</b>			25a. REC'D BY REGISTRAR <b>DATE FEB 26 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



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Medical Examiner Notified & Approved

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
MARIA ROSA MARTIN						2 13 68			
3. SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		F UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		Cauc.		12/24/97		70 YRS.			
7d BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
CUBA		Cuban				PRINCE GEORGE		Md	
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not a hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hyattsville			3801 42nd Ave NW WINDSOR MAVER N.H.			Housewife		own Home	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.			P. G.			Hyattsville		9121 Spring Hill Lane	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Luis Martin			Antonia Portillo						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO			17 INFORMANT Address			
no			none			Nelda E. Armas Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Anemia of undetermined cause</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>2859</u> <u>293x</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebral Vascular Accident</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>11-21</u> , 19 <u>67</u> , to <u>2-13</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>2-2</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
DONALD C. EDGREN						2-13-68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
DONALD C. EDGREN		Hyattsville, Md.							
23a. BURIAL, CREMATION, BURNING (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		2/16/68		Rock Creek		Washington D. C.			
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Francis Gasch's Sons Hyattsville, Md.				DATE FEB 19 1968		Francis Gasch			

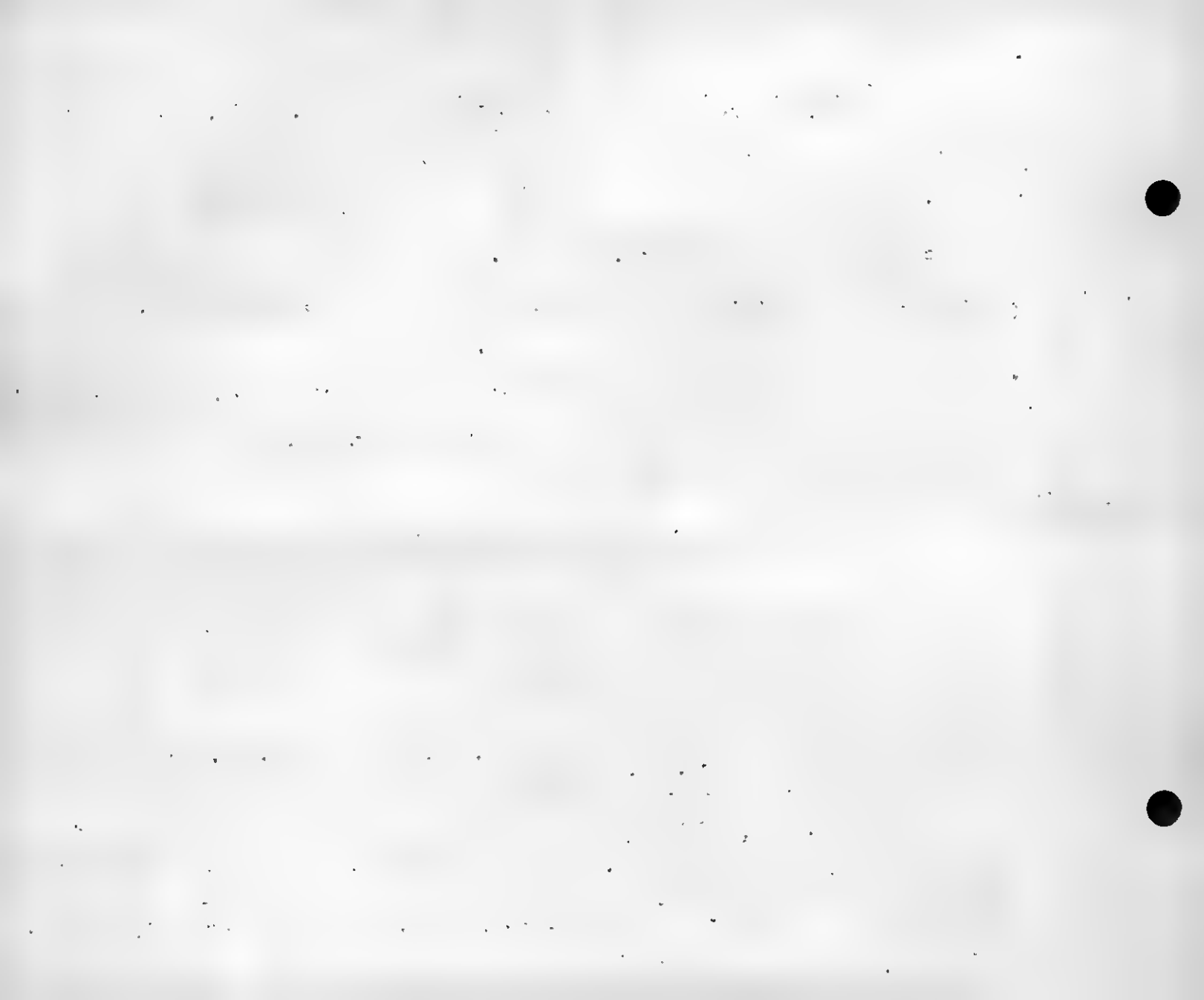


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*Not State Notified*

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print) <i>Garland G.</i>		First <i>Garland G.</i>		Middle		Last <i>MAYES</i>		2a DATE OF DEATH Month <i>Feb.</i> Day <i>24</i> Year <i>1968</i>		2b. HOUR <i>11:25 P</i>	
3 SEX <i>Male</i>		4. RACE <i>Negroid</i>		5 DATE OF BIRTH <i>9/13/03</i>		6 AGE (In years last birthday) <i>64</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i>		IF UNDER 24 HRS HOURS <i></i> MIN. <i></i>	
7a BIRTHPLACE (State or foreign country) <i>North Carolina</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Prince Georges</i>		Md			
10 CITY OR TOWN OF DEATH <i>Cheverly</i>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp. tol give street address) <i>Prince Geo. Gen'l Hospital</i>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Prince Georges</i>		13c CITY OR TOWN <i>Brentwood</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>3924 Allison St.</i>			
14 FATHER'S NAME First <i>Ezia</i> Middle <i>Mayes</i> Last <i></i>		15 MOTHER'S MAIDEN NAME First <i>Cora</i> Middle <i>Tilley</i> Last <i></i>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i></i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <i>Wife</i> <i>Marion Mayes - 3924 Allison St., Brentwood Md.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Massive Intercerebral Hemorrhage, left</i> <i>4271</i> DUE TO, OR AS A CONSEQUENCE OF <i>Cardiomegaly</i> (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF <i>Pulmonary edema and congestion</i> (c) <i></i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <i></i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>4271</i>											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>Feb. 24, 1968</i> , to <i>Feb. 24, 1968</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>Feb. 24, 1968</i> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <del>not</del> view the body after death.											
22b SIGNATURE <i>R. F. RANCHI</i>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>2-26-68</i>					
22d. PHYSICIAN'S NAME (Type) <i>R. F. RANCHI</i>		22e. ADDRESS <i>7729 Finn's Lane, Lanham Md</i>									
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>2-29-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>CARVER Memorial</i>		23d LOCATION (City or Town) (County) (State) <i>Prince George, Md.</i>					
24. FUNERAL DIRECTOR <i>John L. Rhines Co</i>		ADDRESS <i>3015-12th St N.E. Washington D.C.</i>		25a REC'D BY REGISTRAR <i>DATE FEB 29 1968</i>		25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>					

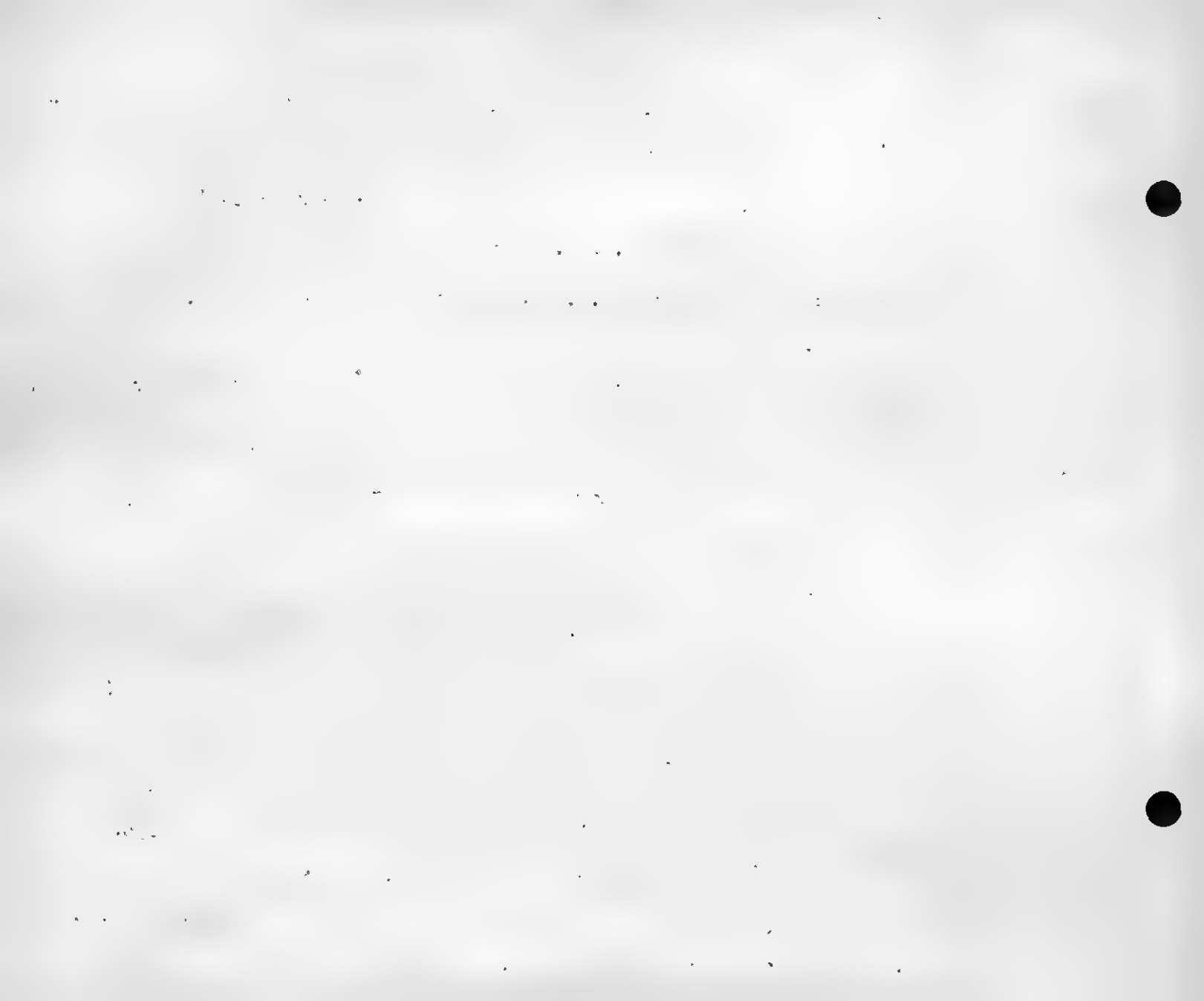




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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) <b>Arthur C McKnew</b>						2a. DATE OF DEATH Month <b>2</b> Day <b>3</b> Year <b>1968</b>			2b. HOUR <b>10:56 A.M.</b>		
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Oct 17 1890</b>			6. AGE (In years last birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.					
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Prince Geo. W. Hyattsville</b>			13c. CITY OR TOWN <b>W. Hyattsville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5813 35th Pl.</b>	
14. FATHER'S NAME First <b>Nathan L</b> Middle <b>McKnew</b> Last <b></b>				15. MOTHER'S MAIDEN NAME First <b>Cora</b> Middle <b>Young</b> Last <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. <b>577 05 6190</b>		17. INFORMANT <b>Maude S Mc Knew</b>				Address <b>West Hyattsville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral and Right Femoral Thrombosis</b> <b>4/24</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b> <b>years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes Mellitus</b>											
19a. DATE OF OPERATION <b>Jan 31, 1968</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Gangrene of Right Leg</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b></b> Year <b>19</b> P.M. <b></b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b></b> City or Town <b></b> County <b></b> State <b></b>							
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 28, 1967</b> , to <b>Feb 3, 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb 2, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Wm H Clements MD</b>						DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/3/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Wm H Clements, MD</b>						22e. ADDRESS <b>6001-35th Ave, Hyattsville, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb 6, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>				23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>			
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>						ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b></b>	

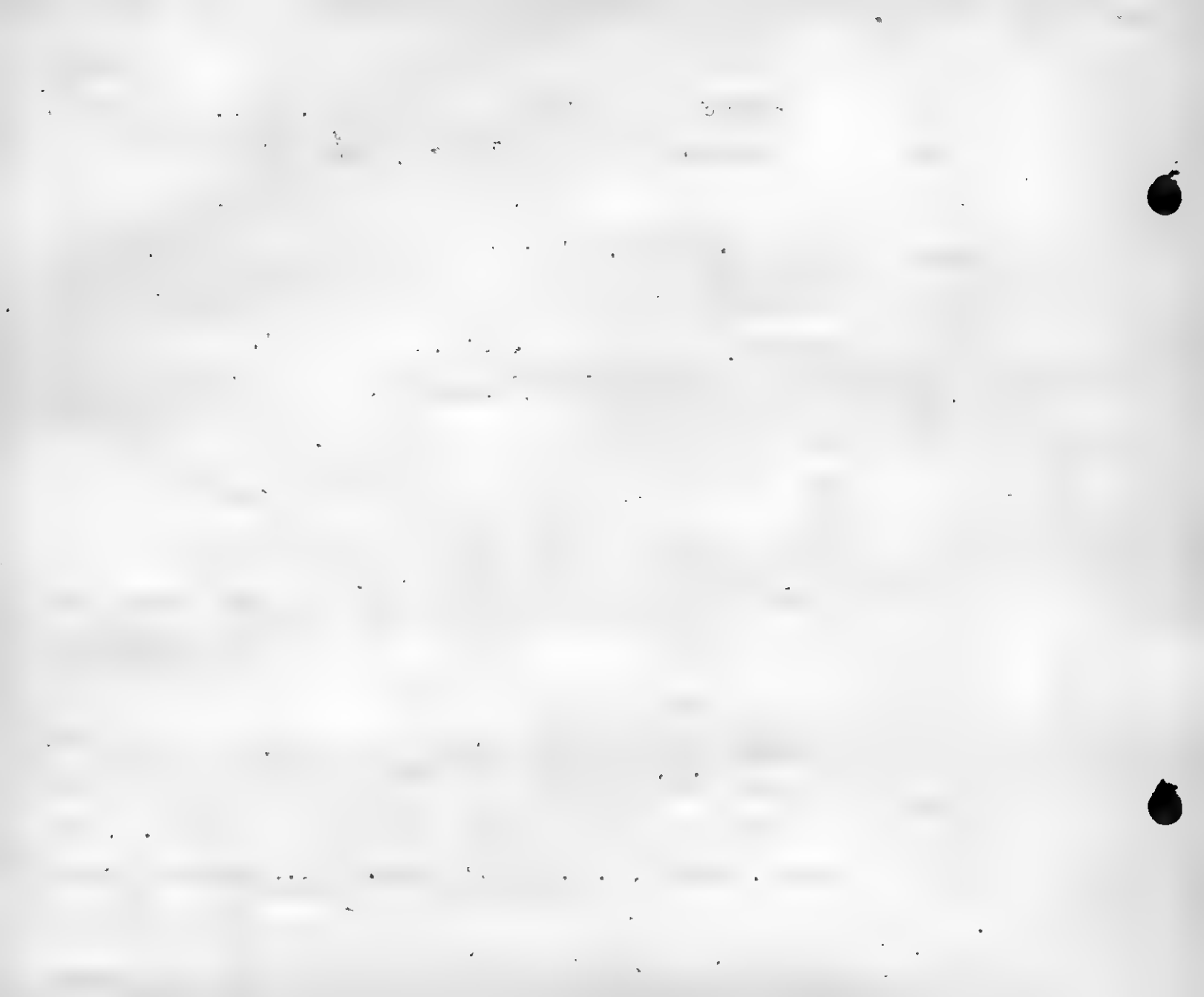


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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print) <b>Frederick W. Meade</b>			2a. DATE OF DEATH Month <b>Feb.</b> Day <b>5</b> Year <b>1968</b>			DOUR <b>6 P M</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Oct 22, 1886</b>		6. AGE (In years last birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>LAND SCAPING</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CAERITZ CO</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before death) <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Landover</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>128 Hunt Avenue</b>	
14. FATHER'S NAME First Middle Last <b>EDWARD MEADE</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>JESSIE BUNCE</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b>		16b. SOCIAL SECURITY NO <b>577 38 0583</b>		17. INFORMANT <b>ROGER MEADE,</b>		Address <b>DUNKIRK, MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4200</b> (b) <b>Arterio-sclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>10 years</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>Auricular fibrillation controlled by digitalis</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <del>(the deceased)</del> attended the deceased from <b>1955</b> , 19____, to <b>Feb. 5,</b> 19 <b>68</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>Feb. 5,</b> 19 <b>68</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(deed)</del> view the body after death.									
22b. SIGNATURE <b>Thomas M. Hutchins</b>				DEGREE <b>Thomas M. Hutchins, M. D.</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>Feb. 6, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>Thomas M. Hutchins, M. D.</b>				22e. ADDRESS <b>7315 Landover Rd., Landover, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>8 FEB 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FORT LINCOLN CEM</b>		23d. LOCATION (City or Town) (County) (State) <b>COLMAR MANOR, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO</b>				ADDRESS <b>RIVERDALE, MD</b>		25a. REC'D BY REGISTRAR <b>Feb 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

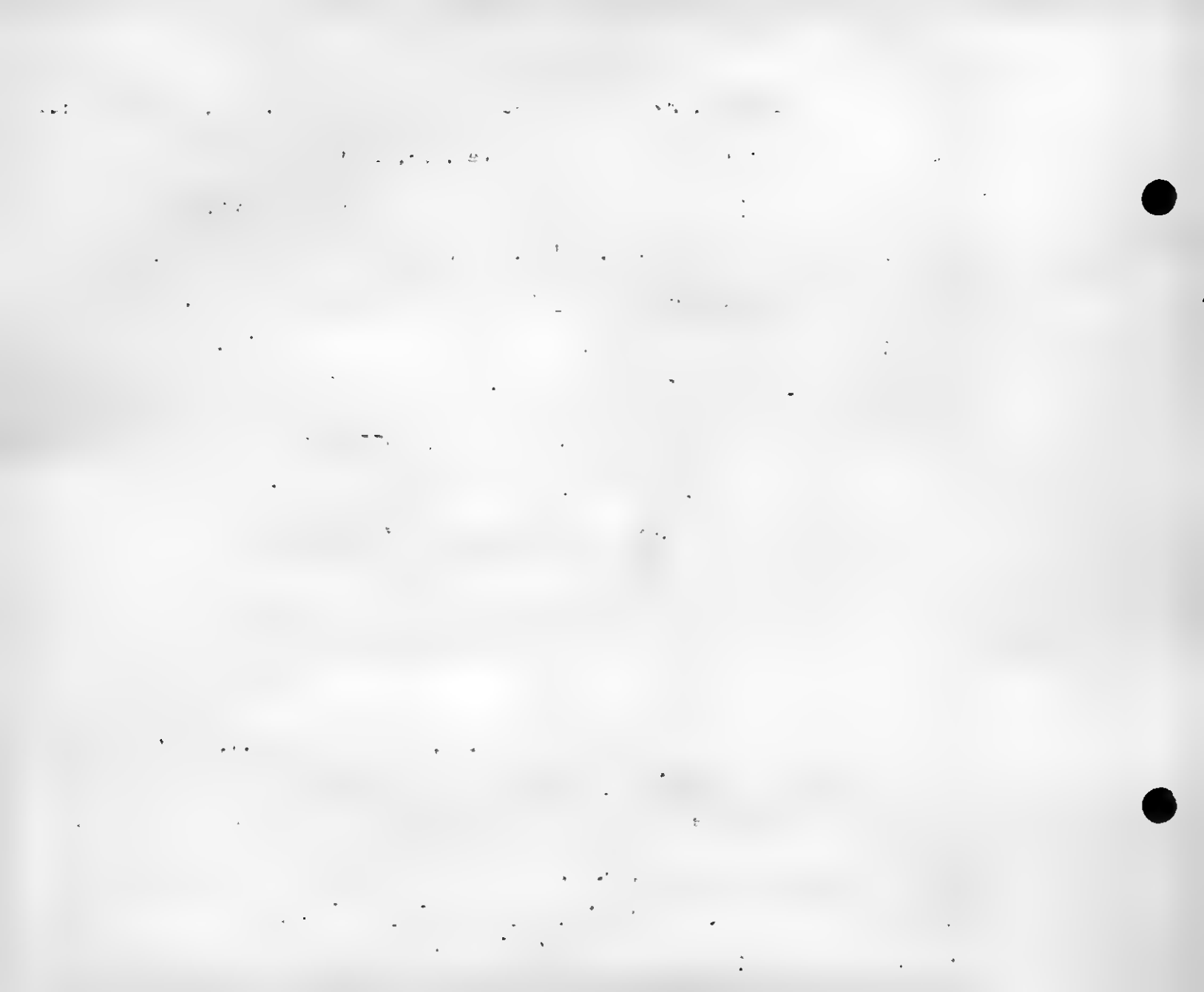


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) <b>Edward KENNETH Miles</b>		2a. DATE OF DEATH Month <b>Feb.</b> Day <b>4</b> Year <b>1968</b>		2b. HOUR <b>9:25P M</b>
3 SEX <b>Male</b>	4 RACE <b>Caucasian</b>	5. DATE OF BIRTH <b>Dec. 19, 1901</b>		6. AGE (In years last birthday) <b>66</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.
10. CITY OR TOWN OF DEATH <b>Cheverly</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Heavy Equipment Operator</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Prince Georges</b>	13c. CITY OR TOWN <b>Capitol Hgts</b>	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>418 50th Ave.</b>
14. FATHER'S NAME First <b>Arthur E</b> Middle <b>Miles</b> Last <b>Miles</b>	15. MOTHER'S MAIDEN NAME First <b>Maggie</b> Middle <b>Matthews</b> Last <b>Matthews</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>	16b. SOCIAL SECURITY NO. <b>225-05-2535</b>	17. INFORMANT Address <b>Eleanor Miles Same as (13e)</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular collapse</b> <b>4170</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardio-vascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pulmonary emphysema, severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 hours</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4241</b>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County State
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Feb. 4, 1968</b> , to <b>Feb. 4, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Feb. 4, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death				
22b. SIGNATURE <b>R. Franchi, M.D.</b>	DEGREE	ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>2-5-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Riccardo Franchi, M. D.</b>	22e. ADDRESS <b>Prince Georges General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>2-8-1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>	23d. LOCATION (City or Town) <b>Southland</b>	(County) (State) <b>Md.</b>
24. FUNERAL DIRECTOR <b>W. W. Chambers Co.</b>	ADDRESS <b>1400 Chapin N.W. Wash. D.C.</b>	25a. READ BY REGISTRAR DATE <b>FEB 8 1968</b>	25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>PRINCE GEORGES</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DISTRICT HEIGHTS</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>7212 Foster Street</b>				d. STREET ADDRESS <b>7212 FOSTER STREET</b>			
3 NAME OF DECEASED (Type or print) First <b>ALBERTINE</b> Middle <b>A.</b> Last <b>MOHLER</b>				4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>23</b> Year <b>1968</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MAY 19, 1895</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>ITALY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>UNKNOWN</b>				14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>ALBERT A. BOSCH, 188 SOMERSET DR. N. J.</b>				Address <b>WILLINGBORO</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF STOMACH WITH METASTASIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1514</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>JANUARY, 1967</b> , to <b>FEB 23, 1968</b> , that (I) (we) last saw the deceased alive on <b>FEB. 22 1968</b> , and that death occurred <b>AT 11 A.M.</b> from causes and on the date stated above							
22a. SIGNATURE <b>Ernest E. Cornelison</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2-23-68</b>	
22c. PHYSICIAN'S NAME (Type) <b>ERNEST E. CORNELISON</b>				22d. ADDRESS <b>5103 MARLBORO PIKE</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/26/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>PRINCE GEORGES, MARYLAND</b>	
24 FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>				25a. REC'D BY REGISTRAR <b>FEB 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





## CERTIFICATE OF DEATH

3349

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY Prince George MARYLAND						2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b STATE Md. b COUNTY Prince George									
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel				c LENGTH OF STAY IN lb		c CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Laurel									
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Laurel General Hospital						d STREET ADDRESS 1018 Bond Mill Road						e IS RESIDENCE ON A FARM? YES [ ] NO [X]			
3 NAME OF DECEASED First Middle Last Herbert Moller						4 DATE OF DEATH Month Day Year 2 4 19 68									
5 SEX Male		6 COLOR OR RACE White		7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		8. DATE OF BIRTH 3/16/14		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b KIND OF BUSINESS OR INDUSTRY Wash. Sub. Sanitary		11 BIRTHPLACE (County & State, or foreign country) Wash. D. C.				12 CITIZEN OF WHAT COUNTRY? USA					
13 FATHER'S NAME Frank Moller						14 MOTHER'S MAIDEN NAME Lena Hoffmann									
IS WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16 SOCIAL SECURITY NO. 577-01-7413		17 INFORMANT Mrs. Herbert Moller Jr Address									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: <u>Lympho sarcoma</u> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last. (b) DUE TO (c)														INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]	
20a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d INJURY OCCURRED While at work [ ] Not While at work [ ]		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 1963, 19 to 2/4, 1968, that (I) (we) last saw the deceased alive on 2/4/1968, and that death occurred at 3P.M. from causes and on the date stated above.															
22a SIGNATURE [Signature] PHYSICIAN'S NAME (Type) FRANK L WEAVER JR						ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]		22b. DATE SIGNED							
23a BURIAL CREMATION REMOVAL (Specify)				23b. DATE THEREOF 2-7-68		23c NAME OF CEMETERY OR CREMATORY Long Hill Cem.		23d LOCATION (City or Town) (County) (State) Laurel Md.							
24 FUNERAL DIRECTOR Dr. Walter Langsdorf						ADDRESS Laurel Md		25a REC'D BY REGISTRAR FEB 13 1968		25b REGISTRAR'S SIGNATURE [Signature]					



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Mary Sue Moran						2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 2-22-68		19:40pm	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER YEAR	8 IF UND 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	2-16-1931	37 YRS	MONTHS	DAYS	Month 2 Day 22 Year 68		19:40pm	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md.	
Kentucky		USA				Prince George's			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Riverdale			Ireland Memorial Hospital			Housewife		None	
13a USUAL RESIDENCE (Where deceased lived, if not last residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d STREET AND NUMBER	
Maryland			Prince George			Laurel		933 Park Hill Road	
14. FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Carroll Baker			Margaret Adams						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17 INFORMANT		ADDRESS	
no						Margaret Adams		Daphnerville Kentucky	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gun shot wound of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
2-22-68			Gun shot wound of head			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
App. 3:00am			2-22-68			Shot self in head with .22 cal. rifle.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION (Street or R.F.D. No. City or Town County State)			
			home			same as #13			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		2-23-68	
John Kehoe MD			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Burial			Feb 26, 1968			BALTIMORE NATL Cem			BALTIMORE MD
24. FUNERAL DIRECTOR			ADDRESS			25a. RE'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
DeWitt Donaldson			Laurel Md.			FEB 27 1968		Charles Judge	



# FDR STATE HEALTH DEPT.

TO DEPUTY CLERK EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
Evelyn Henrietta Morton						ESTIMATED MONTH DAY YEAR		6:15 P.M.	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD	
female	Negro	4-26-25	1942 YRS	MONTHS	DAYS	HOURS	MIN	Month 2 Day 1 Year 1968	2d HOUR 6:41 P.M.
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Virginia		U.S.A.				Prince George's Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Cedar Heights			6416 H Street			Cafeteria Worker		H.S.A.	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER
Md.			P.G.		Cedar Hts.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6416 H Street
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
John L. HARRIS			Pearl Jackson						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
No			None			Pearl Harris 6416-H St. Cedar Hts Md			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver Failure</u> 5-11-68 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cirrhosis of liver</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks Years
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 3-10									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 item 18)				
			19						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED			
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland			ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>			2-3-68			
			DEPUTY MED. CAL. EXAMINER <input checked="" type="checkbox"/>						
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
			2-6-68		Harmony		Highland Park Md		
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE			
H.S. Washington & Sons 4925 Deane Ave NE			DATE FEB 8 1968			James Judge			



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03061

VR A15ME (5)  
10M REV 1/68



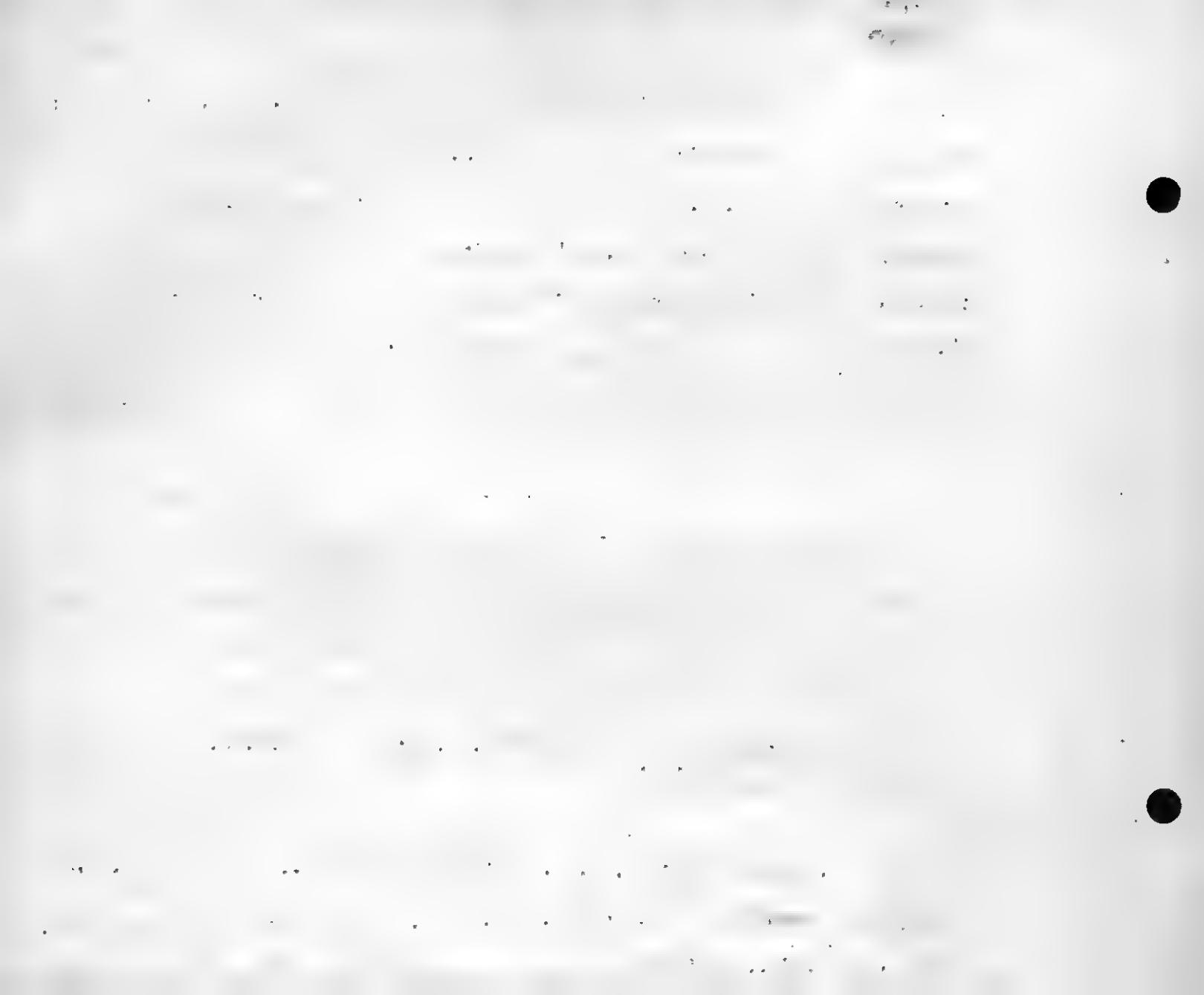


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
M

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
Baby Boy Moy						Feb. Month 6, Day 1968 Year		1:25 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		Caucasian		Feb. 6, 1968		YRS.		1 21		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		U. S.				Prince Georges		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince Geo. Gen'l Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince Georges		Greenbelt		YES <input type="checkbox"/> NO <input type="checkbox"/>		6118 Breezwood Court	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
Ming Moy			Mee Chunlee							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>immaturity</u> 717 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>premature labor</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 30 hrs.										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 776 X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (the hospital) attended the deceased from Feb. 6, 1968, to Feb. 6, 1968, that (I) (we) saw the deceased alive on Feb. 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>R. Kennedy Skipton, M.D.</u>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.		22c. DATE SIGNED 2-6-68		
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
R. Kennedy Skipton, M. D.				4500 College Ave., College Park, Md. 20740						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 3/2/68		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Cremation				Prince Geo. Gen. Hosp.		Cheverly PG Md.				
24. FUNERAL DIRECTOR <u>Harry W. Penn, Jr., Administrator</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
				MAR 11 1968		<u>Charles Judge</u>				



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

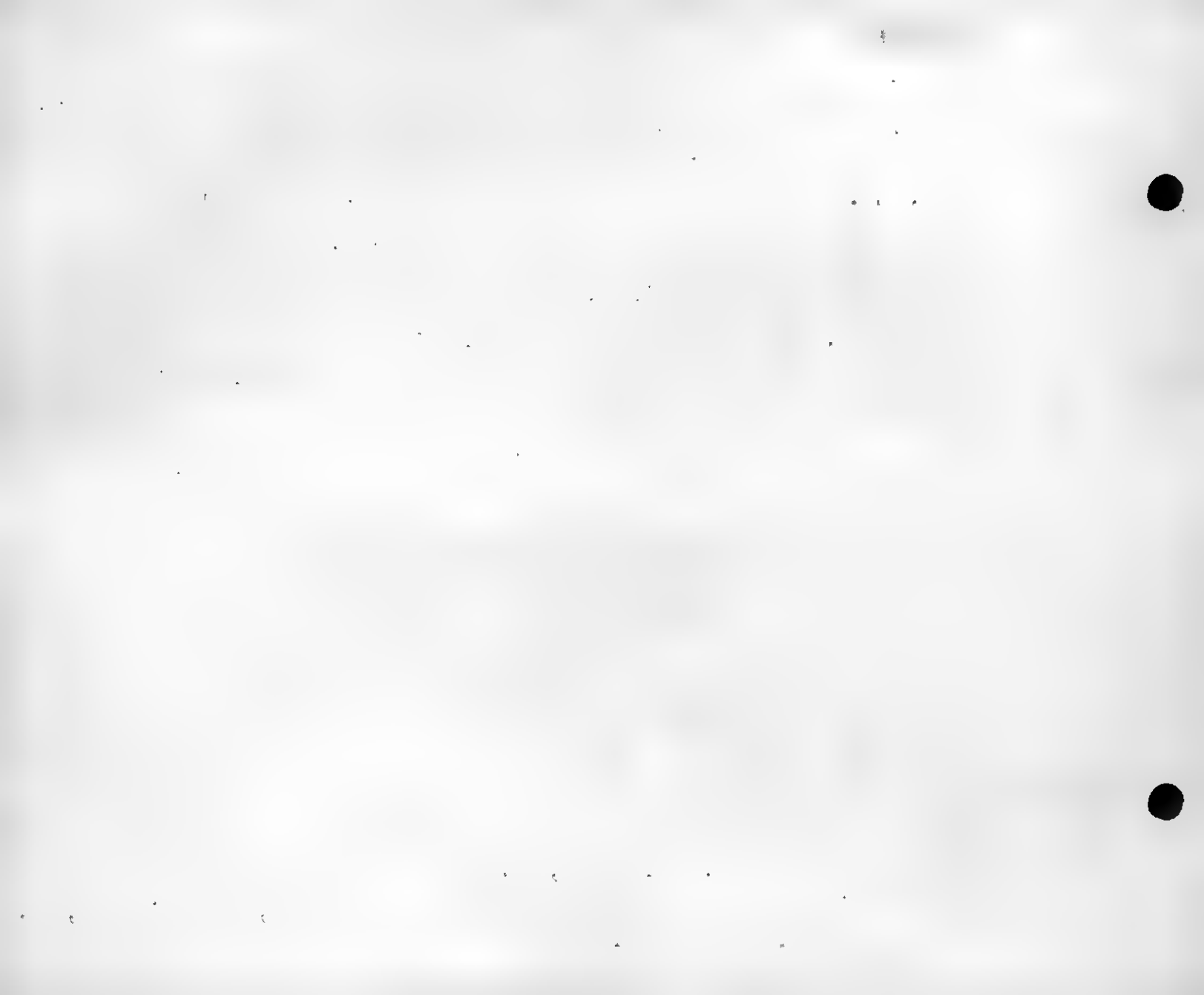
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

03063

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3048

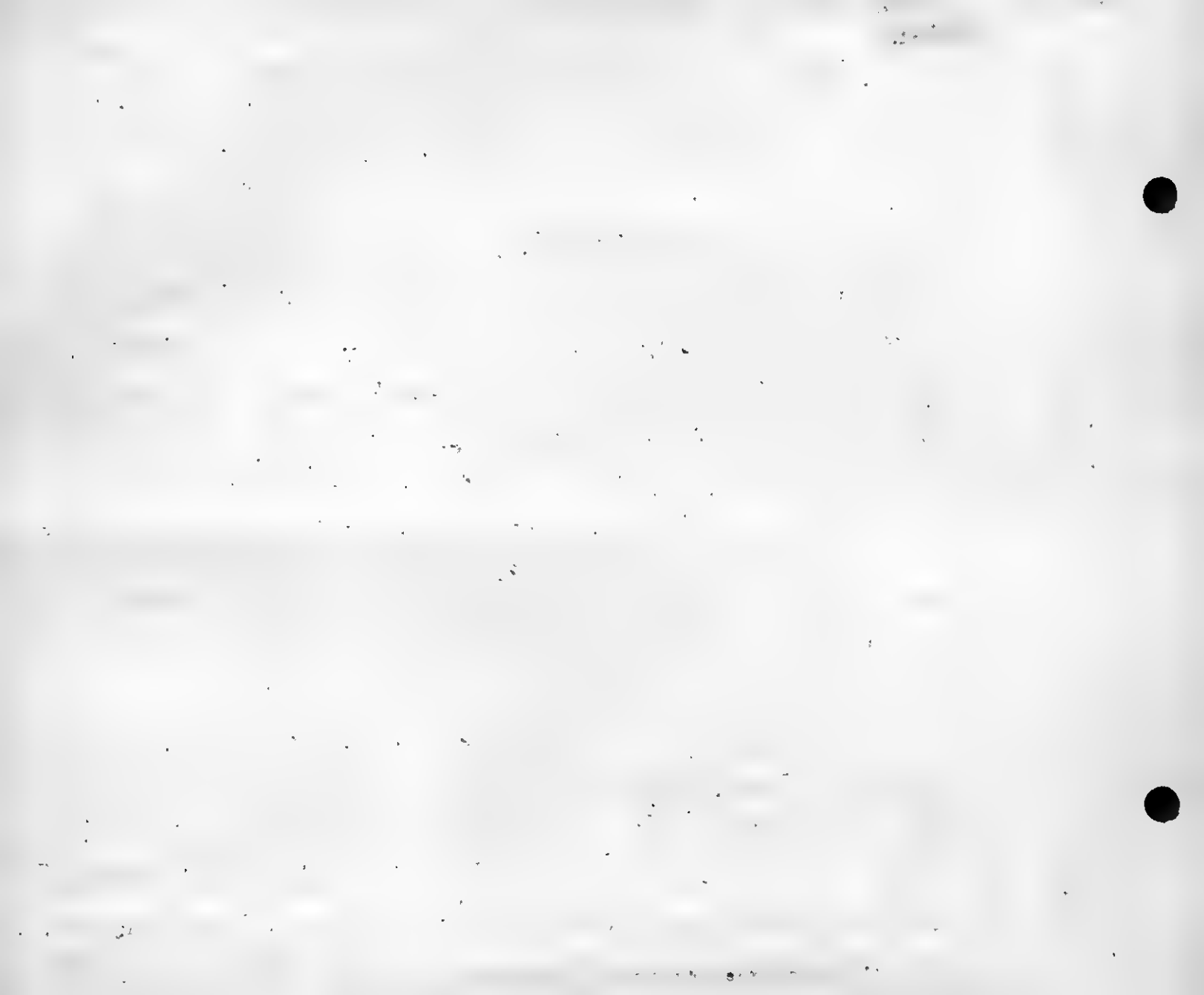
1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year		2b HOUR
Catharine Agnes Murphy					2-5-68 19 4:00aM		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	7 UNDER 1 YEAR MONTHS DAYS HOURS	8 UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Female	White	30X Sept. 1911	28X			2 5 68 19 4:50aM	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Wash. D.C.		USA				Prince George's Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp ital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince George Hospital		Secretary		Theatre	
13a USUAL RESIDENCE (Where deceased lived, if institut in Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland		Prince George's District Heights				6002 Surrey Square Lane	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First Middle Last
Harry E. Burch					Mary Louise Tennyson		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT		900 ADDRESS Whamm Avenue	
No				Marsha Murphy Titus,		McLean, Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure							minutes
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease							unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)		John Kehoe, M.D.		ASS STANT MED. CA. EXAMINER <input type="checkbox"/>		2-5-68	
		Riverdale, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		2/8/68		Cedar Hill Cemetery		Suitland, Prince Georges, Md.	
24. FUNERAL DIRECTOR				25a RECD BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Robert E. Wilhelm Funeral Home				DATE FEB 13 1968			
4308 Suitland Road, Suitland, Maryland							



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled may the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

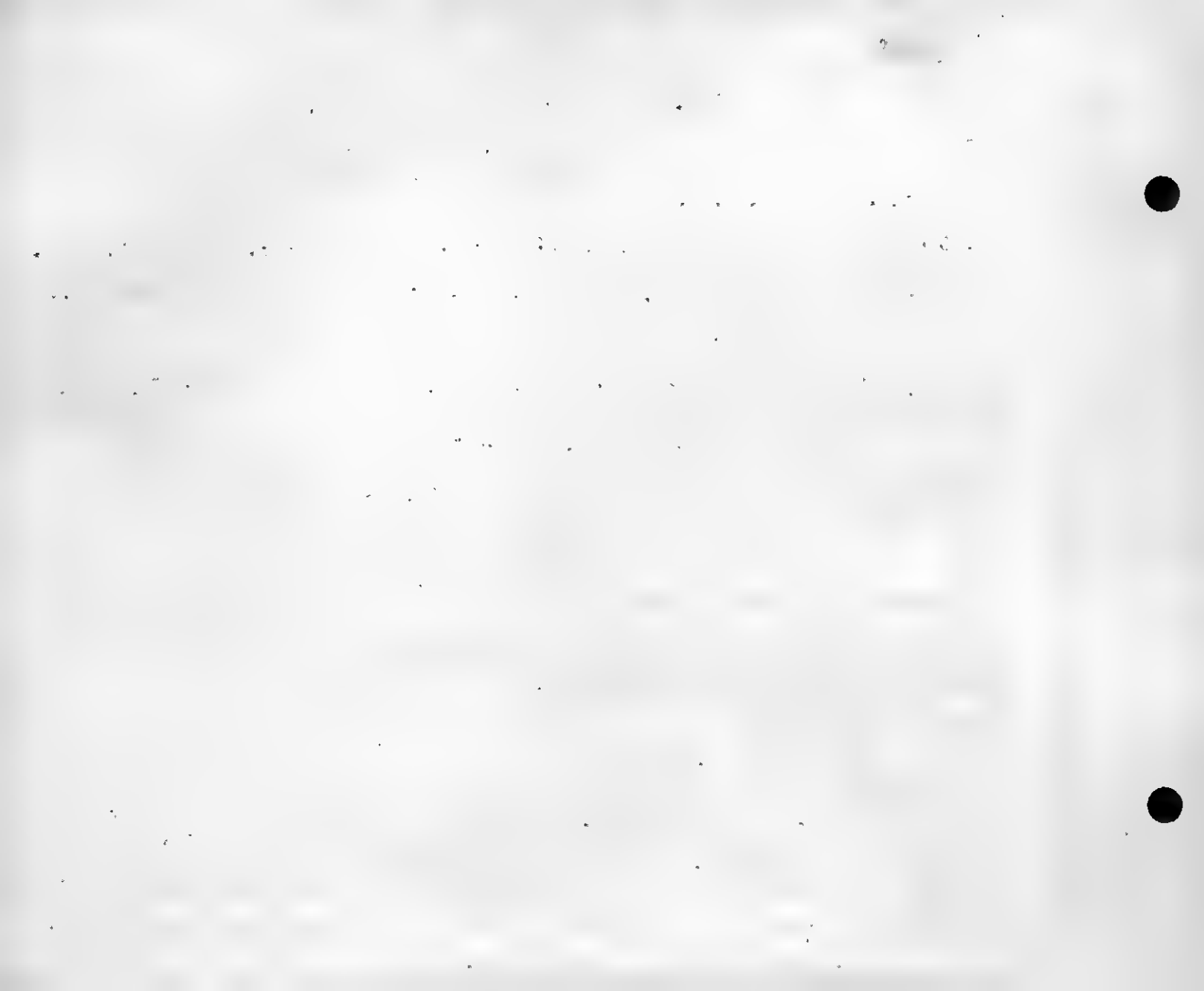
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or print) <b>Laura</b>			First <b>B</b>			Middle <b>Marys</b>			2a. DATE OF DEATH Month <b>2</b> Day <b>16</b> Year <b>68</b>			2b. HOUR <b>9:00 A M</b>	
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>3-20-1882</b>			6. AGE (in years last birthday) <b>85</b> YRS.			IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Phila. Pa.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Prince George</b> Md.				
10. CITY OR TOWN OF DEATH <b>Adelphi Md.</b>			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>PAINT BRANCH 3120 Powder Mill Rd.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>P. Neo.</b>			13c. CITY OR TOWN <b>Londover Hills</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER <b>7100 Taylor ST.</b>	
14. FATHER'S NAME First <b>Henry</b> Middle <b></b> Last <b>Behrens</b>			15. MOTHER'S MAIDEN NAME First <b>May</b> Middle <b></b> Last <b>STERNOGLE</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>—</b>			17. INFORMANT <b>Rosamary Wilson</b> Address <b>7100 Taylor - L. Will</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b>													
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic congestive heart failure</b>													
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary arteriosclerotic CVD.</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Bronchitis - 4 days.</b>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (this hospital) attended the deceased from <b>8-26</b> , 19 <b>64</b> to <b>2-16</b> , 19 <b>68</b> , that (we) last saw the deceased alive on <b>2-14</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>R.D. Bauer M.D.</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>2-16-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>R.D. Bauer, M.D.</b>						22e. ADDRESS <b>2513 Buck Lodge Rd. Adelphi, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>2/19/67</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Lakeview Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Cinnaminson Burlington N. J.</b>				
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Maryland</b>						25a. REC'D BY REGISTRAR <b>FEB 26 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
03065 CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
CHARLES C. NICHOLSON						Feb. Month 3 Day 68 Year		10/25 PM		
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		F UNDER 1 YEAR MONTHS DAYS		
Male		White		July 21, 1889		78 YRS.		IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Penn.		U. S. A.				Prince Georges		Md.		
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
Hyattsville		Madison Manor 42nd Ave.		Retired Engr.		Pub. Inst.'s				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md		Prince Georges		College Park				9534 Rhode Island ave.,		
14 FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last	
John A Nicholson						Anna C Anderson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		Address				
no		712 09 4408 A		George E. Anderson		College Park, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>410.9</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>420</u>										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> hat while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 1</u> , 19 <u>67</u> , to <u>Feb 3</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>Feb 2</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>R. Deitz M.D.</u> DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED <u>2/4/68</u>				
22d. PHYSICIAN'S NAME (Type) Dr R Deitz				22e. ADDRESS Pro Geo Plaza Hyattsville, Md.						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		Feb 7, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.				
24 FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Judge</u>				
				DATE FEB 8 1968						





03066  
Item 5 Film G398 3/4/68 ap

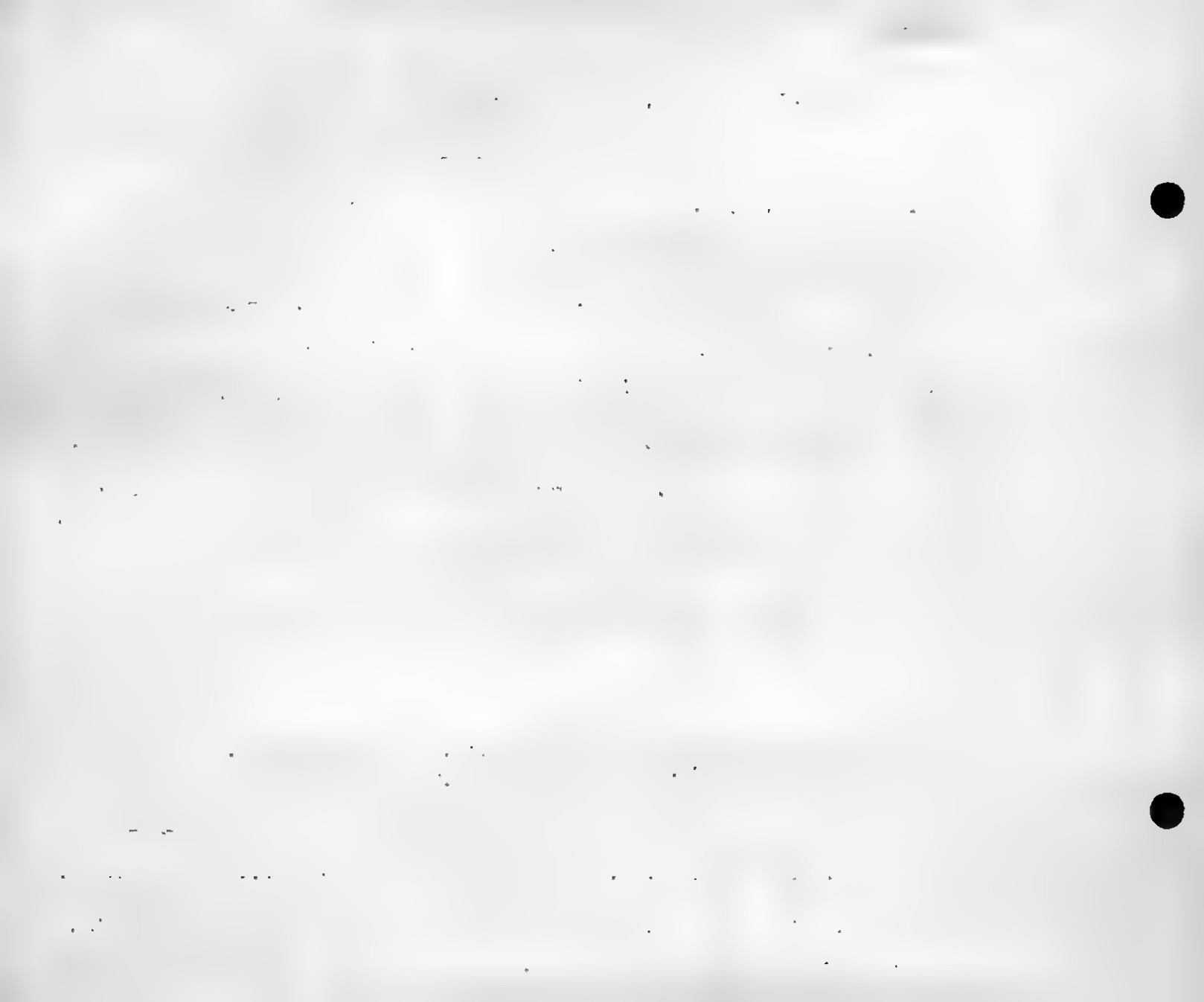
## CERTIFICATE OF DEATH

03051

1. DECEASED-NAME (Type or print) First Middle Last <b>Daniel C. Noldy</b>			2a. DATE OF DEATH Month Day Year <b>February 22, 1968</b>		2b. HOUR <b>7:35a.m.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>March 19, 1885</b> <del>3-19-86</del>		6. AGE (In years lost birthday) <b>82</b> YRS.	7. FUNERAL 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Pa.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md	
10. CITY OR TOWN OF DEATH <b>Riverdale</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Eugene Leland Memorial</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>	13b. COUNTY <b>Prince Georges</b>	13c. CITY OR TOWN <b>Brentwood</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>4321 - 39th Place</b>	
14. FATHER'S NAME First Middle Last <b>Frederick Noldy</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Wilhelmia Ranke</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>579 034 271A</b>	17. INFORMANT Address <b>Medical Record/Granddaughter</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF <b>Gen. Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>unknown</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 mos.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <b>P. 19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>12 Jan., 1968</b> , to <b>22 Feb., 1968</b> , that (I) (we) last saw the deceased alive on <b>21 Feb., 1968</b> , and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(I)</b> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>C. J. Houmann</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2-22-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>C. J. Houmann, M. D.</b>		22e. ADDRESS <b>4400 Queensbury Rd., Riverdale, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Feb 26, 1968-</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
Harry			E.		Ohlsen	2 Month 5 Day 68 Year			2:00A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
Male		White		1/22/87		81 YRS.				
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New York			USA				Prince Georges Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Riverdale			Eugene Deland Memorial			Retired				
13a. USUAL RESIDENCE (Where deceased admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Prince Georges		Riverdale		XX		5401 Riverdale Road	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last	
Harry			E.		Ohlsen	Hana			Beebe	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT					
Yes			220-44-1869		Hospital Records					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thromboses</u> <u>433.4</u> DUE TO, OR AS A CONSEQUENCE OF <u>General arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4 deep undetermined</u> (c) <u>undetermined</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>332</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 28, 1967</u> to <u>Feb 5, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb 4, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>LW Malin</u> DEGREE <u>MD</u> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <u>2-5-68</u>						
22d. PHYSICIAN'S NAME (Type) <u>LW Malin M.D.</u>				22e. ADDRESS <u>Riverdale, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		Feb 8, 1968		Ft Lincoln Cemetery			Colmar Manor Pro Geo Md.			
24. FUNERAL DIRECTOR				ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
F. Gasch's Sons				Hyattsville, Md.			DATE FEB 8 1968		<u>[Signature]</u>	

21

I

no

no

no

no

no

no

no

no

no

no

no

no

no

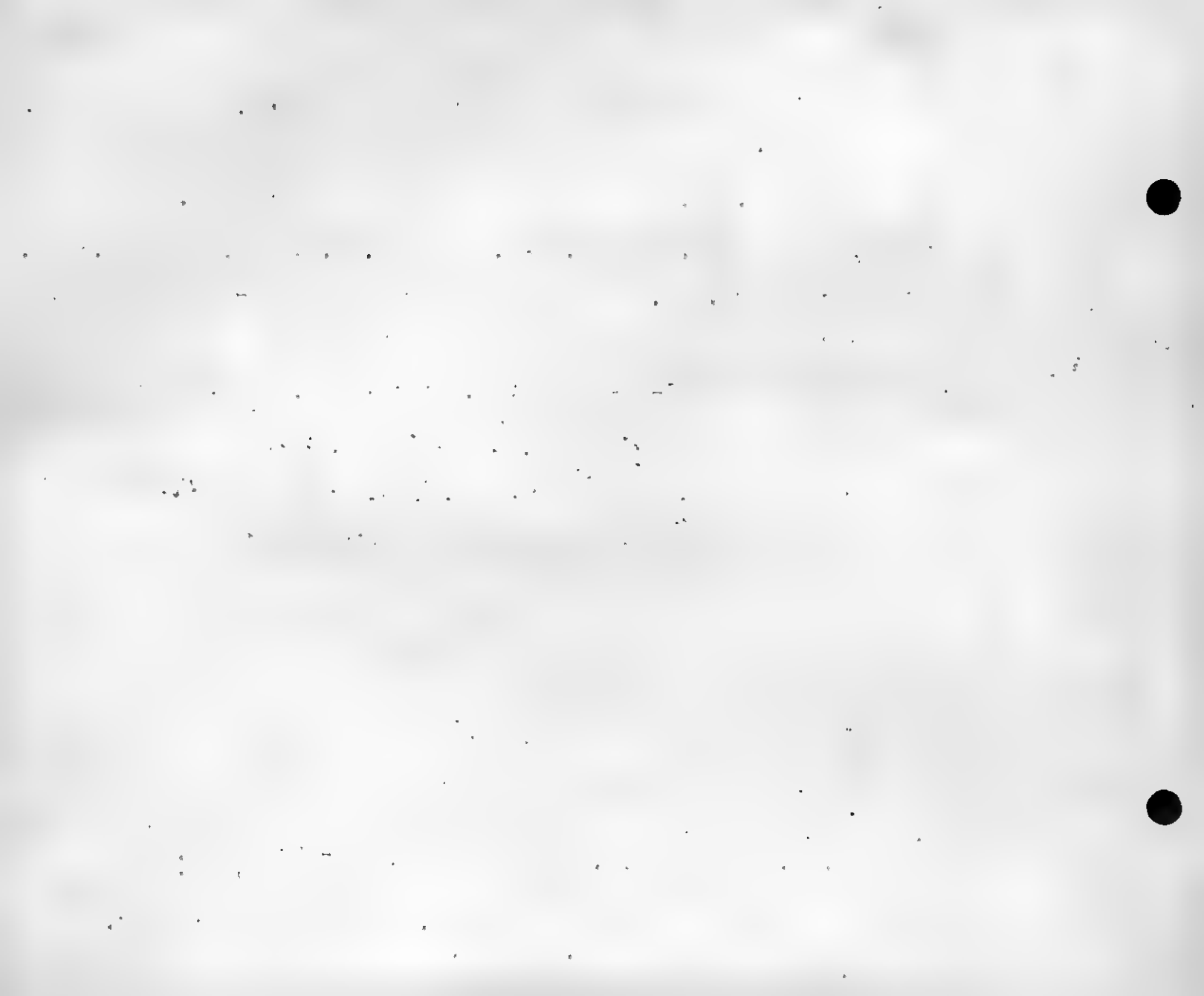
no

no

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

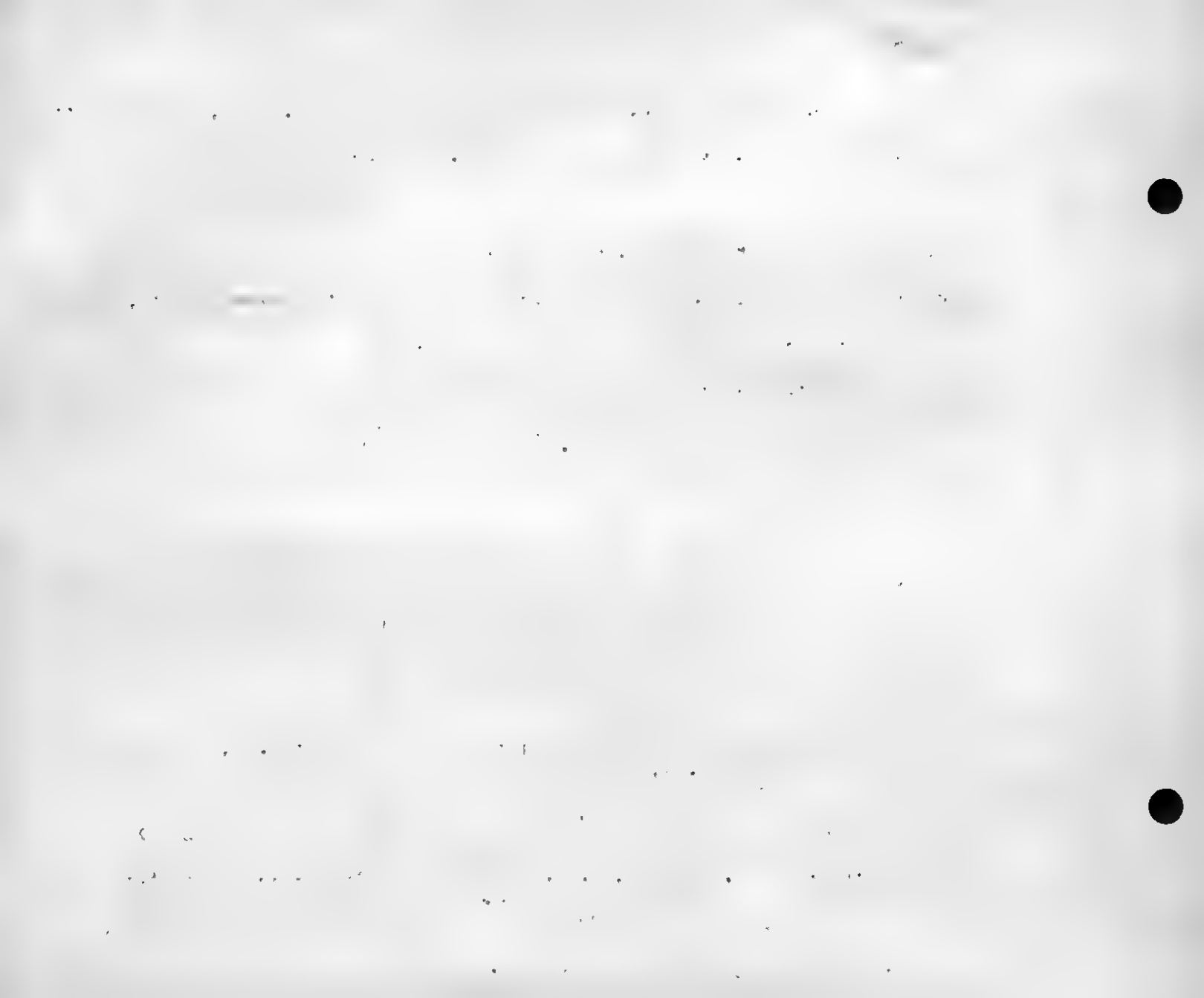
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First William		Middle S.		Last Ott		2a. DATE OF DEATH Month Day Year Feb. 5 1968		2b. HOUR 5:55 PM
3. SEX Male		4. RACE White		5. DATE OF BIRTH 5/22/1896			6. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Ohio		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Geo. Md.				
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pr. Geo. Gen. Hosp.				12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) Ret. U.S. Govt.		12b. KIND OF BUSINESS OR INDUSTRY Dep. Agri.		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5602- Elberton Pl.		
14. FATHER'S NAME First Middle Last Henry Ott			15. MOTHER'S MAIDEN NAME First Middle Last Unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes		16b. SOCIAL SECURITY NO. 217-42-3658		17. INFORMANT Mrs. Katherine A. Ott (above address)		Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis, Acute</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Systemic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized atherosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last 4201 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that (I) this hospital attended the deceased from Oct 1960, to Feb 5, 1968, that (II) (we) lost the deceased alive on Nov 6, 1967, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (do not) view the body after death.										
22b. SIGNATURE William D. Rosson, M.D.				22c. DATE SIGNED 2/8/68		22d. PHYSICIAN'S NAME (Type) Wm. D. Rosson, M.D.				
22e. ADDRESS 5701 - 85th Ave. Hyattsville, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/9/68		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cem.		23d. LOCATION (City or Town) Colmer Manor, Md.		(County) (State)		
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				25a. REC'D BY REGISTRAR DATE FEB 13 1968		25b. REGISTRAR'S SIGNATURE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year			2b. HOUR
Nellie M. Phillips						Feb. 2, 1968			12:20A
3 SEX	4 RACE		5. DATE OF BIRTH			6 AGE (In years lost birthday)		7. IF UNDER YEAR MONTHS DAYS HOURS MIN	
Female	Caucasian		Dec. 14, 1884			83 YRS.			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pa		U S A				Prince Georges Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince Geo. Gen'l Hospital		Housewife		Home			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
Maryland		Prince Georges		Clinton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Kerman St. Pine View Gardens, Stewart	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Thomas Henry Smith			Ann Adams						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
no			187 22 7106A		Mrs Robert Johnson		Lanham, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric ulcer with intestinal obstruction DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 531.1									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis with extensive heart failure (concomitant disease)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 1/16, 1968, to Feb. 2, 1968, that (I) (we) saw the deceased alive on Feb. 2, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Frederick H. Wilhelm, M.D.				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2/3/68	
22d. PHYSICIAN'S NAME (Type) Frederick H. Wilhelm, M. D.				22e. ADDRESS 6319 Landover Road, Cheverly, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATOR		23d. LOCATION (City or Town) (County) (State)			
Burial		Feb 7, 1968		Monongahela Cemetery		Monongahela Washington Pa			
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				ADDRESS		25a REC'D BY REGISTRAR DATE FEB 6 1968		25b. REGISTRAR'S SIGNATURE	





## CERTIFICATE OF DEATH

03070

03056

1. DECEASED-NAME (Type or print) <b>Baby Boy Pratt</b>			2a. DATE OF DEATH Month <b>Feb</b> Day <b>5</b> Year <b>68</b>			2b. HOUR <b>5:10 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb., 4 1968</b>		6. AGE (In years last birthday) YRS. MONTHS DAYS <b>24</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.M</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pr. Geo. Gen. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>P.C.</b>		13c. CITY OR TOWN <b>Laurel</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>610 Main Street</b>		14. FATHER'S NAME First Middle Last <b>Donald I. Pratt</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Patricia Ann Deutsch</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give year or dates of service)	
16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pulmonary insufficiency etc</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Respiratory distress syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) <b>John R. Buell</b> attended the deceased from <b>Feb 4</b> , 19 <b>68</b> , to <b>Feb 5</b> , 19 <b>68</b> , that (I) <b>(w)</b> saw the deceased alive on <b>Feb 4</b> , 19 <b>68</b> , and that in my <b>(w)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(w)</b> (did) <b>(did not)</b> view the body after death.							
22b. SIGNATURE <b>John R. Buell, M.D.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>2/5/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>John R. Buell, M.D.</b>				22e. ADDRESS <b>8116 Gorman Ave., Laurel, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>2/10/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PRINCE GEORGE'S GENERAL</b>		23d. LOCATION (City or Town) (County) (State) <b>CHEVERLY, MARYLAND</b>	
24. FUNERAL DIRECTOR <b>W. PENN. JR. ADMINISTRATOR</b>				HOSPITAL REC'D BY REGISTRAR <b>FEB 13 1968</b>		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-101. This delay is not to be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Mary			Lessie Proctor			Month Day Year		192:15pm	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	F UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Female	Negro	2-5-1903	65 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year	2d. HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		USA				Prince George's Md			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp. list give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Hospital			HW			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution on residence before)			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland			Charles County Indian Head		YES <input type="checkbox"/> NO <input type="checkbox"/>		#9 6th. Street		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
George Swann			Bertha Swann						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT				
No			220-16-9051		Indian Head, Md. Edward L. Proctor, #9-6th St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Heart failure</u>									
DUE TO, OR AS A CONSEQUENCE OF <u>Hypertensive cardio vascular disease over 3 mo.</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) _____									
DUE TO, OR AS A CONSEQUENCE OF _____									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Diabetes mellitus - over 3 months.</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			HOUR A.M. P.M.		19				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			2-6-68			
John Kehoe, M.D. Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town or county)			
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			Feb. 9, 1968		St. Joseph's		Pomfret, Charles, Md.		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Arehart Funeral Home Inc., La Plata, Md.					DATE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or offending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

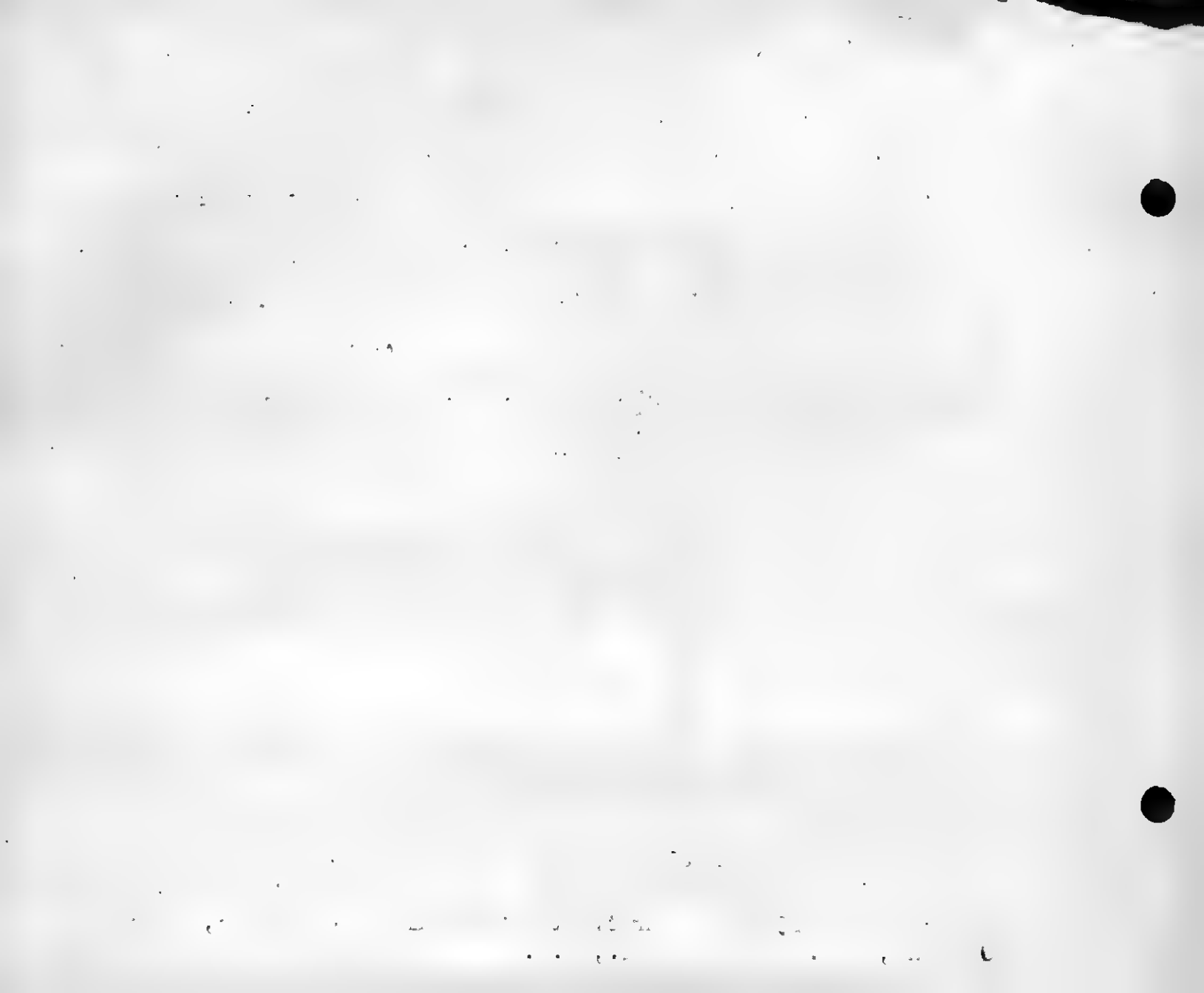
1

03072

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

03057

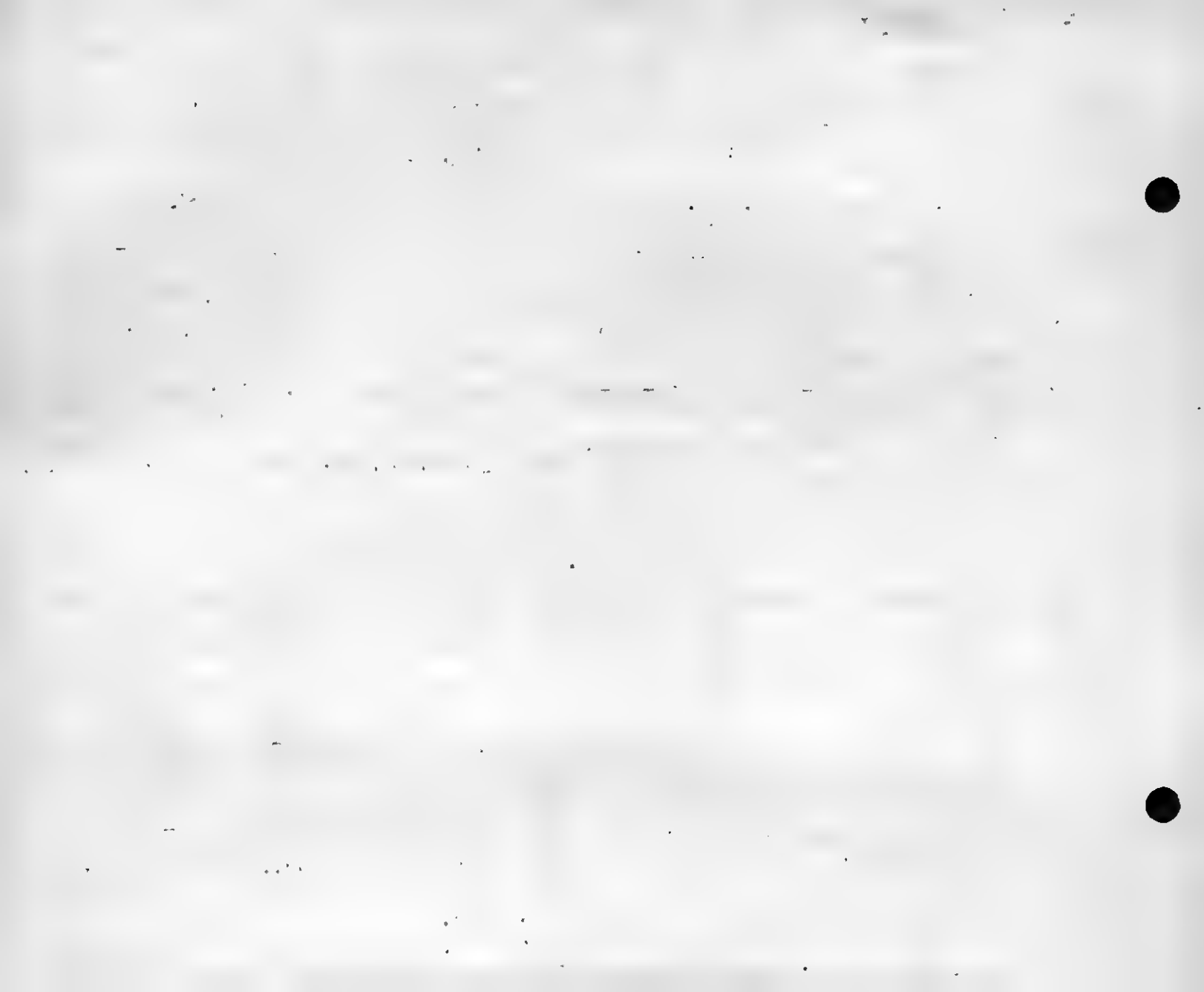
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
NANNIE				C.	PROCTOR	FEB 24 1968			845A <sup>M</sup>		
3 SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.	
FEMALE		NEGRO		9 Sep 1914		53 YRS.					
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
NORTH CAR		U.S.A.				PRINCE GEORGE'S Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY		
ANDREWS AFB			USAF Hospital			HOUSEWIFE			NONE		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
MARYLAND			Prince Geo		Cedar Hts				1021 64th Ave		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Unknown						NANCY					JONES
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
NO			NA			JAMES T. PROCTOR, SAME AS # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HEPATIC COMA</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 Months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>13 Dec</u> , 19 <u>67</u> , to <u>24 Feb</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>24 Feb 68</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Arnold L. Klipstein</i>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 24 FEB 68			
22d PHYSICIAN'S NAME (Type) ARNOLD L. KLIPSTEIN CAPT USAF, MC						22e. ADDRESS Malcolm Grow USAF HOSPITAL Andrews AFB, Wash. D.C.					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		County		State	
Burial		2/29/68		Arlington National		Arlington, Virginia					
24 FUNERAL DIRECTOR Rollins, Inc. 4339 Hunt Pl., N.E.						25a. REC'D BY REGISTRAR DATE FEB 28 1968		25b REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) Margaret S Pryor				2a. DATE OF DEATH Month 2 Day 12 Year 68				2b. HOUR 11:57pm			
3 SEX Female		4 RACE White		5. DATE OF BIRTH 1 Feb. 1889		6. AGE (In years last birthday) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George's Md					
10. CITY OR TOWN OF DEATH Cheverly		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) housewife		12b. KIND OF BUSINESS OR INDUSTRY -					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Riverdale		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5820 66th. Avenue			
14. FATHER'S NAME First Middle Last William S. Fowler				15. MOTHER'S MAIDEN NAME First Middle Last Margaret E. Shoemaker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO. 577-05-6069		17. INFORMANT Address Miss Margaret C. Carroll (above address)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 6 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4200											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from Oct. 1962, to 1-23-1968, that (I) (we) lost the deceased alive on 1-23-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE John Kehoe MD				DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-13-68			
22d. PHYSICIAN'S NAME (Type) John Kehoe MD				22e. ADDRESS 6300 Riverdale Rd., Riverdale, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/15/68		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION (City or Town) (County) (State) Colmar Manor, Md.					
24. FUNERAL DIRECTOR Nalley's Funeral Home Inc.				ADDRESS Mt. Rainier Maryland		25a. REC'D BY REGISTRAR DATE FEB 16 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

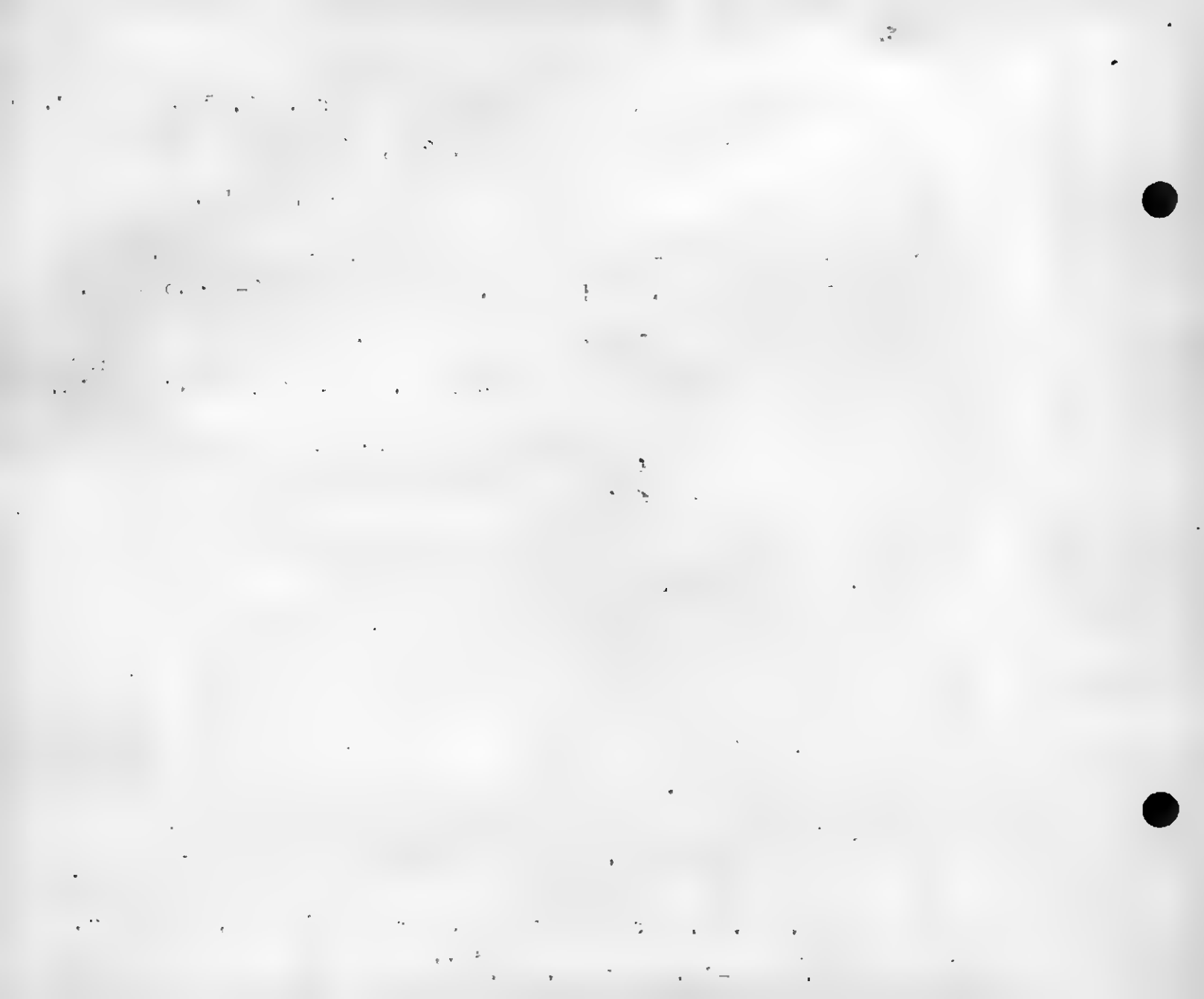




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First William		Middle A.		Last Purdy		2a DATE OF DEATH Month Day Year Feb. 23, 1968		
3 SEX Male		4 RACE White		5 DATE OF BIRTH Aug. 7th, 1890			6 AGE (In years last birthday) 77 YRS		7b HOUR 7 A.M.		
7a BIRTHPLACE (State or foreign country) Maryland			7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Pr. Geo'S.				
10 CITY OR TOWN OF DEATH District Heights			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 7402- Kenova Street			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Retired		12b KIND OF BUSINESS OR INDUSTRY DC. Transit			
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Maryland			13b. COUNTY Pr. Geo'S		13c. CITY OR TOWN Dist. Heights		13d. INSIDE CITY LIMITS? NO		13e. STREET AND NUMBER 7402- Kenova St.		
14. FATHER'S NAME First Middle Last William Purdy			15. MOTHER'S MAIDEN NAME First Middle Last Josephine Wells			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. 578-10-6267		
17 INFORMANT Bernice J. Dulaney (Dau.)			Address Same as # 13.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute myocardial infarction, probably</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4277</u> (b) <u>coronary arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH SUDDEN DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CEREBRAL THROMBOSIS											
19a. DATE OF OPERATION -			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. II			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC. <u>and on 2nd Avenue</u>			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 2, 1968</u> , to <u>2. 23, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb. 2, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Orvil C Morris</u>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2. 23 68.</u>			
22d. PHYSICIAN'S NAME (Type) <u>Dr. Orvil C Morris</u>						22e. ADDRESS <u>2121 PENNSYLVANIA AVE WASHINGTON DC</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE Feb. 26.68.		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Suitland, Maryland.				
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>						ADDRESS Wash. SE. DC		25a. REC'D BY REGISTRAR DATE FEB 26 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate shall be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

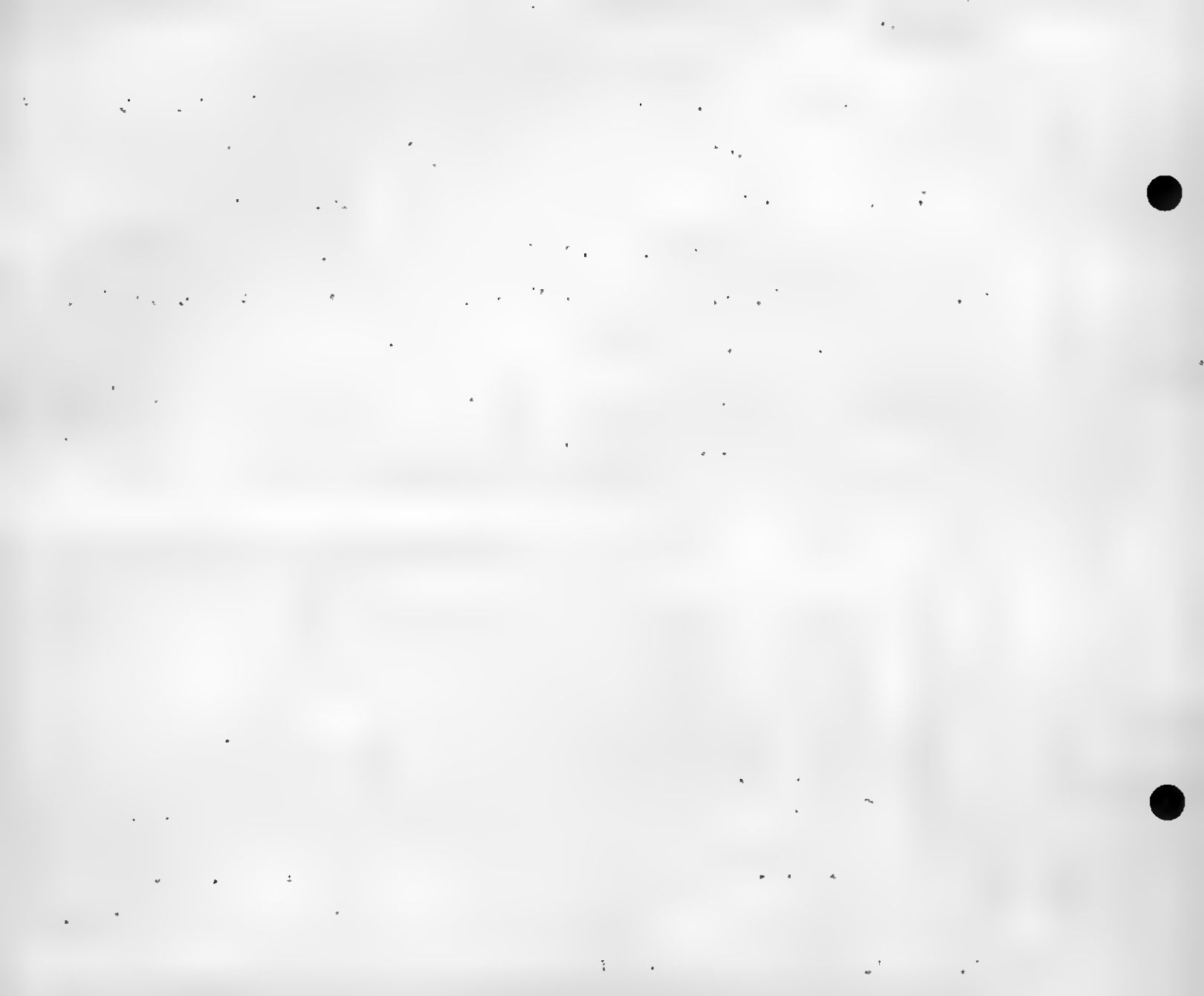
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year		2b. HOUR		
George Morrison Rafferty						2-20-68 15:00		m M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year		
Male	White	23 Sept. 1902	65 YRS					2 20 68 19 5:15pm M		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Pennsylvania		U.S.A.				Prince George's Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Machinist				
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Penna.			Phila.		S.W. Philadelphia		YES		5900 Harley Dr., 3B	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
John Rafferty			Louise Monroe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
					Mrs. Louise Meehan-168		Fairless Hills, Pa. Lincoln Hwy.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u> Cond. trans, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>over 5 yrs.</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>420</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>John Kehoe</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type) <u>Prince George Co. John Kehoe MD</u>			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			2-20-68				
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county) <u>Riverdale, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Removal		2-22-1967		Philadelphia Memorial Pk.		Philadelphia, Pa.				
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>				ADDRESS <u>5130 Wisc. Ave. N.W.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
				<u>Washington, D.C.</u>		DATE <u>FEB 26 1968</u>		<u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
George E. Reed						Month 2 Day 22 Year 63		9:50 P.M.		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		
M		White		10/11/33		84 YRS.		MONTHS DAYS HOURS MIN		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Mass.		USA				Prince Georges Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Riverdale			Leland Memorial			Rigger		Shipyard		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Md.			P. G.		E. Riverdale		YES <input type="checkbox"/> NO <input type="checkbox"/>		6308 62nd Place-	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
Willard B. Reed			Elizabeth Rogers							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b SOCIAL SECURITY NO.		17. INFORMANT Address					
					Fred. Reed 6308 - 62nd Pl E Riverdale					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION									IMMEDIATE	
DUE TO, OR AS A CONSEQUENCE OF (b) GEN ARTERIOSCLEROSIS									UNKNOWN	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from JAN 2, 1968, to FEB 22, 1968, that (I) (we) last saw the deceased alive on FEB 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE C. J. Houmann				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 23 FEB 1968				
22d. PHYSICIAN'S NAME (Type) Dr. C.J. Houmann				22e. ADDRESS 4400 Queensbury Rd. Riverdale						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		2/26/68		Westport Cemetery		Westport Mass.				
24. FUNERAL DIRECTOR ADDRESS				25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
F. Gasch's Sons Hyattsville, Maryland				DATE FEB 27 1968						

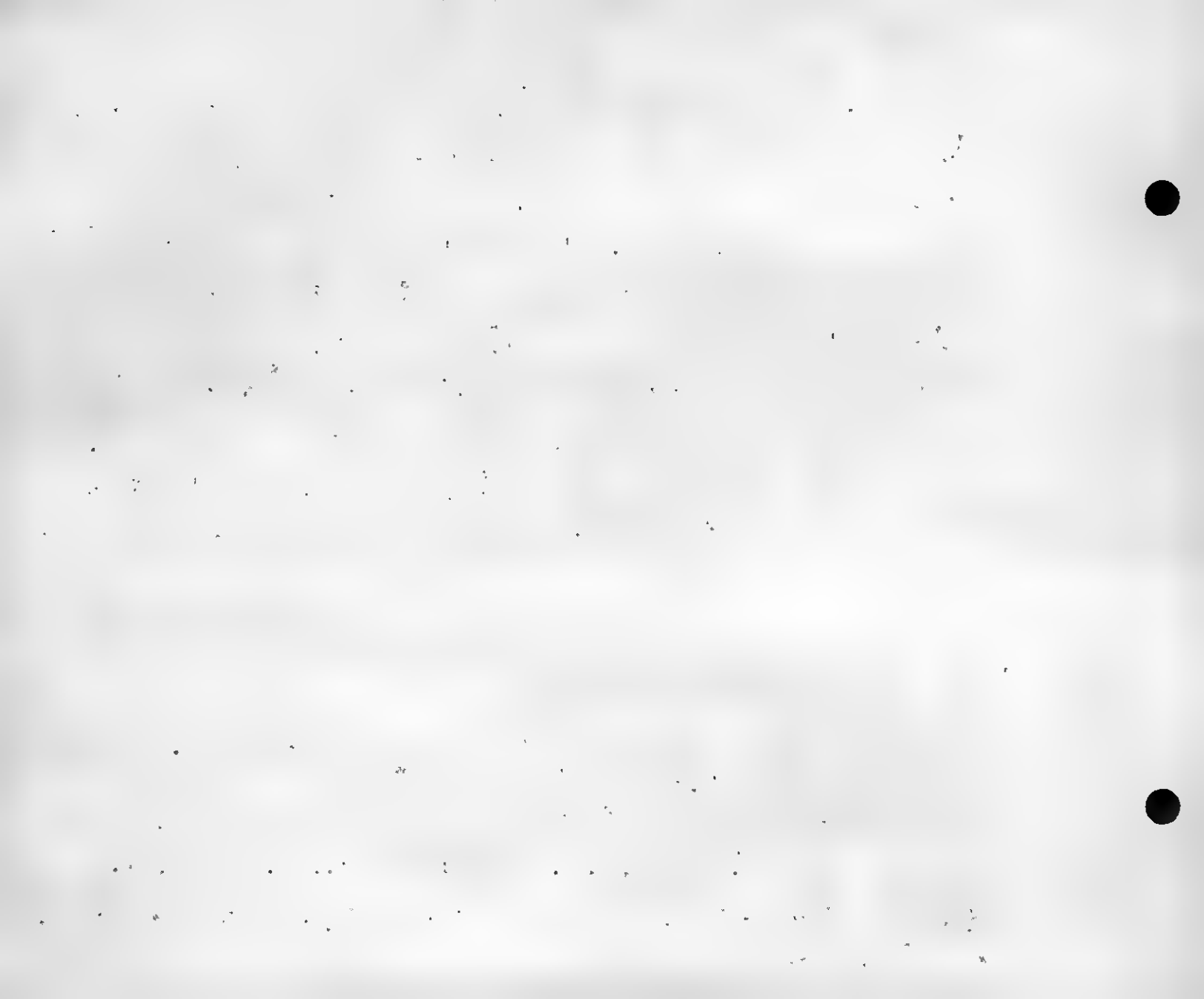


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) <u>Roscoe Belle Reed</u>			2a. DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1968</u>			2b. HOUR <u>2:55 A.M.</u>	
3 SEX <u>Female</u>		4 RACE <u>White</u>		5. DATE OF BIRTH <u>July 13, 1880</u>		6 AGE (In years last birthday) <u>87</u> YRS.	
7a. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <u>Prince Georges</u> Md.	
10. CITY OR TOWN OF DEATH <u>Cheverly</u>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Prince Geo. Gen'l Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE <u>Maryland</u>		13b. COUNTY <u>Prince Georges</u>		13c. CITY OR TOWN <u>Brentwood</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <u>3719 Sheppard Street</u>							
14. FATHER'S NAME First <u>JOHN</u> Middle <u>DAVIS</u> Last			15. MOTHER'S MAIDEN NAME First <u>CECILE</u> Middle <u>HICKSON</u> Last				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>NO</u> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <u>NONE</u>		17 INFORMANT <u>WILLIAM F. CORNWELL</u> Address <u>RT 2 BOX 174. EDGEWATER MD.</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> <u>412.0</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atrial Fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive Cardiovascular Dis.</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost <u>Heart.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>14 min</u> <u>20 days</u> <u>Years</u>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>742</u>							
19a. DATE OF OPERATION <u>7-4-68</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Jan 30, 1968</u> , to <u>Feb 19, 1968</u> , that (I) <u>(did)</u> saw the deceased alive on <u>2/18</u> 1968, and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(have)</u> (did) <u>(not)</u> view the body after death.							
22b. SIGNATURE <u>Charles C. Hageage</u> M.D.				22c. DATE SIGNED <u>2/19/68</u>		22d. PHYSICIAN'S NAME (Type) <u>Charles C. Hageage, M. D.</u>	
22e. ADDRESS <u>3308 Perry St., Mt. Rainier, Md.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>21 Feb-1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort LINCOLN Cem</u>		23d. LOCATION (City or Town) (County) (State) <u>COLMAR MANOR, MD.</u>	
24. FUNERAL DIRECTOR <u>W. W. CHAMBERS Co., RIVERDALE, MD</u>				25a. REC'D BY REGISTRAR DATE <u>FEB 21-1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J...</u>	





CERTIFICATE OF DEATH

306.5

1. DECEASED-NAME (Type or print) <b>THOMAS D. Reid</b>			2a. DATE OF DEATH <b>2</b> Month <b>13</b> Day <b>68</b> Year			2b. HOUR <b>2:48</b> PM			
3. SEX <b>M</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Sept. 27, 1886</b>		6. AGE (In years last birthday) <b>81</b> YRS		IF UNDER 1 YEAR MONTHS <b>5</b> DAYS <b>16</b>	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges Co.</b> Md.			
10. CITY OR TOWN OF DEATH <b>Clinton Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Clinton Community Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Clinton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Rt 1 Box 594 Clinton, Md.</b>	
14. FATHER'S NAME First <b>Samuel</b> Middle <b>Reid</b> Last			15. MOTHER'S MAIDEN NAME First <b>Sarah</b> Middle <b>Darby</b> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>No</b> (If yes, give year or dates of service)		16b. SOCIAL SECURITY NO. <b>579-28-6165A</b>		17. INFORMANT Address <b>Pearl P. Reid, wife, PO Box 48 Clinton, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>RESPIRATORY ARREST</b> <b>4127</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CEREBROVASCULAR ACCIDENT ACUTE</b> DUE TO, OR AS A CONSEQUENCE OF <b>WITH LEFT HEMIPLEGIA</b> (c) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MIN.</b> <b>10 DAYS</b> <b>8 YRS.</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>NONE</b>									
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>None</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <b>None</b> Month <b>None</b> Day <b>None</b> Year <b>None</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>None</b>					
21d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>None</b>		21f. LOCATION Street or R.F.D. No. <b>None</b> City or Town <b>None</b> County <b>None</b> State <b>None</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 1966</b> to <b>PRESENT</b> , that (I) (we) last saw the deceased alive on <b>FEB 12 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Arthur Shaver Jr</b>				22c. DATE SIGNED <b>Feb 13, 1968</b>					
22d. PHYSICIAN'S NAME (Type) <b>ARTHUR SHAVER JR</b>				22e. ADDRESS <b>8808 BRANCH AVE CLINTON, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/16/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Church Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Barnesville, Maryland</b>			
24. FUNERAL DIRECTOR <b>Robert E. Wilhelm Funeral Home</b> <b>4308 Suitland Road, Suitland, Maryland</b>				25a. REC'D BY REGISTRAR <b>FEB 16 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

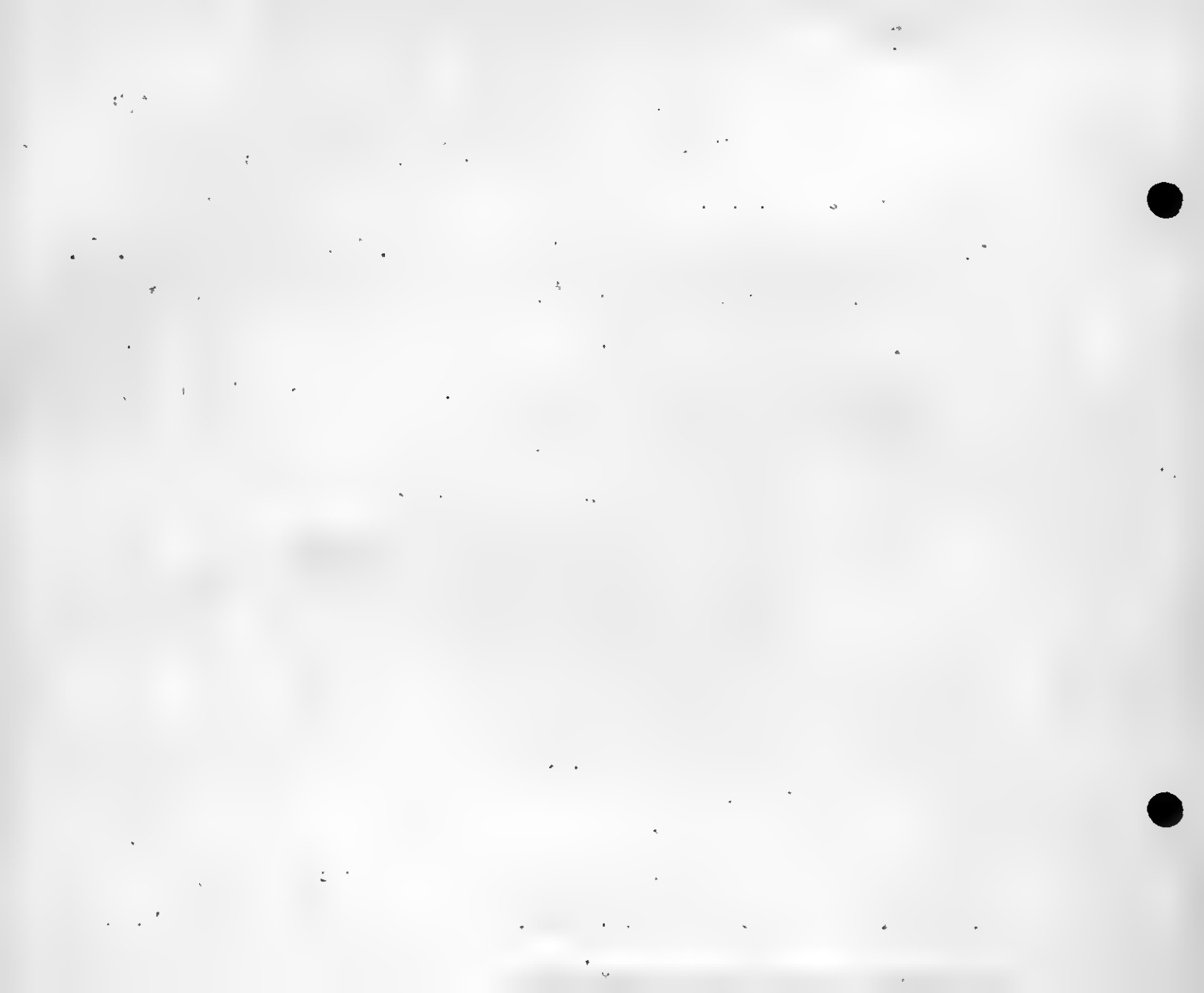
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print) <b>Elias C. Renn</b>						2a. DATE OF DEATH Month <b>2</b> Day <b>18</b> Year <b>1968</b>		2b. HOUR M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 12, 1893</b>		6. AGE (in years last birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARR. ED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George</b> Md.			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Ret. Agent</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Life Ins. Co.</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Prince George</b>		13c. CITY OR TOWN <b>University Park</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6305 Queens Chapel Road</b>	
14. FATHER'S NAME First Middle Last <b>Frederick Renn</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Hannah Stackhouse</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (a. or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16b. SOCIAL SECURITY NO <b>138 07 4090</b>		17. INFORMANT Address <b>Edna M. Renn Same as #13 (wife)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma</b> <b>162.1</b> DUE TO, OR AS A CONSEQUENCE OF Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchogenic carcinoma.</b> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR. CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 1967</b> , to <b>Feb. 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb. 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Robert Deitz, M. D.</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>2/19/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Robert Deitz, M. D.</b>				22e. ADDRESS <b>Prince George Plaza Hyattsville, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE <b>2/21/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P.G. Md.</b>			
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>FEB 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>			



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VR A15 (4)  
25M 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Washington, D.C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN TB <b>7 mos 2 wks</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Abraham Richardson</b>		4. DATE OF DEATH Month <b>2</b> Day <b>24</b> Year <b>19 68</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/8/1903</b>
9. AGE (In years last birthday) <b>64</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cook</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Richardson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Williams</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>579-01-5515</b>	
17. INFORMANT <b>Decedent</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Carcinoma of Gallbladder with metastases</b> DUE TO (b) <b>1560</b> DUE TO (c) <b>1557</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>Unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis; arteriosclerosis, mild</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>7/5</b> , 19 <b>67</b> , to <b>2/24</b> , 19 <b>68</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>2/24</b> , 19 <b>68</b> , and that death occurred at <b>8:40 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Moe Weiss</b>		22b. DATE SIGNED <b>2/24/68</b>	
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-28-68</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Sutton Rd. Md</b>	
24. FUNERAL DIRECTOR <b>H.S. Washington &amp; S. 4925 Dams</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 1 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Jones</b>			

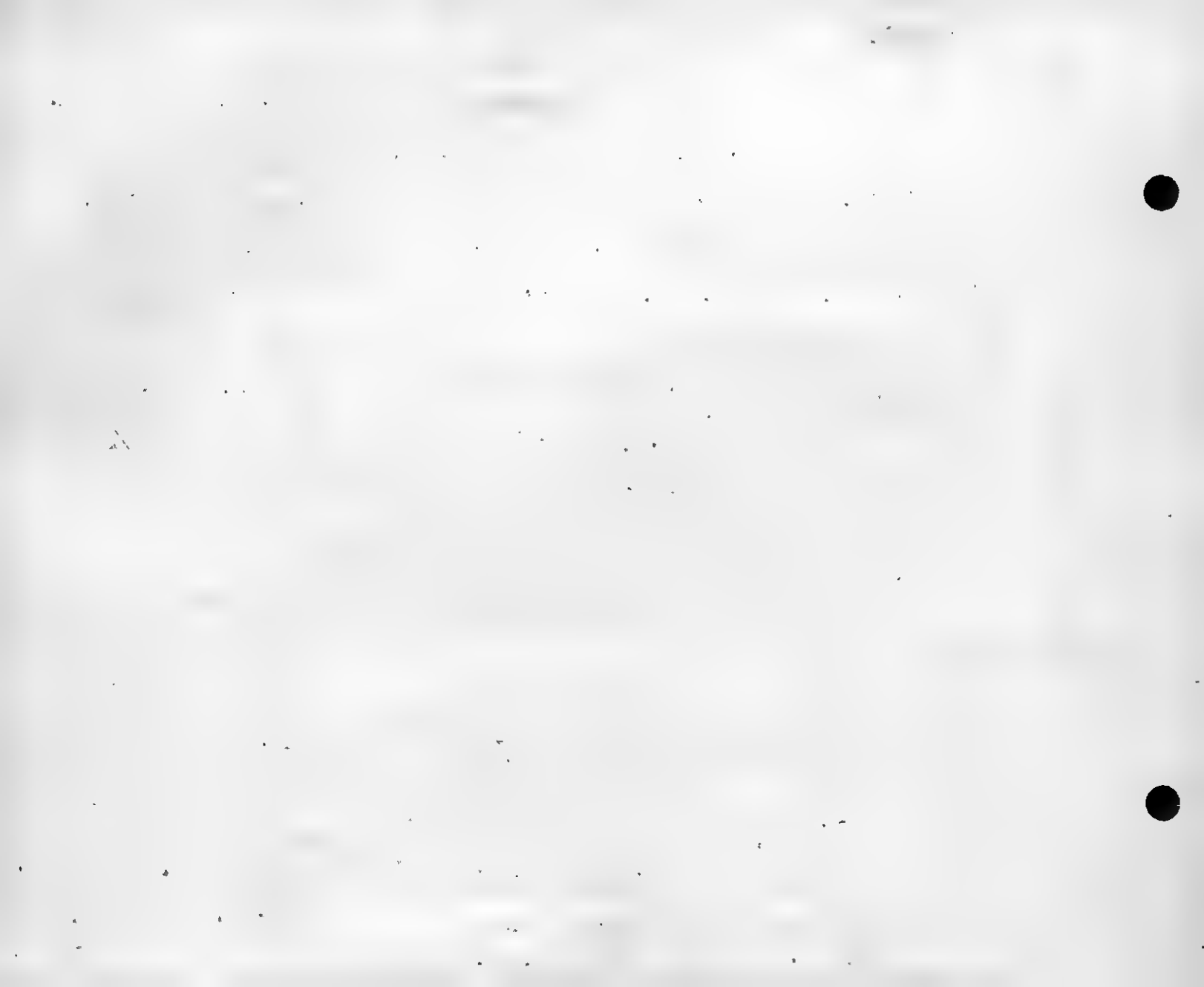


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR		
Mary Rogers						Feb. Month 29 Day 1968 Year			12:30 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Female		White		Dec. 31, 1892		75 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Arkansas		U S A.				Prince Georges County		Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Lanham		Magnolia Gardens Nursing		Practical Nurse		Hospital					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Md.			Pr. Geo.		Hyattsville		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6707 Eldridge Street		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
John N Cook						Virginia Carlos					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address		
no			579 26 4837			Mary V Garrity			Hyattsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) myocardial infarction									10 min		
DUE TO, OR AS A CONSEQUENCE OF											
(b) arteriosclerotic heart disease									2 yrs		
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
+ 1.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18)							
		HOUR A.M. Month Day Year P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				1/15/1967							
22a. I certify that (I) (this hospital) attended the deceased from 1/15/1967, to 2/29/1968, that (I) (we) last saw the deceased alive on 2/29/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
Leon R Levitsky, MD		2/29/68									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
Leon R Levitsky, MD		3908 Rhode Island Ave N.W. D.C.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		March 4, 1968		Ft Lincoln Cemetery		Colmar Manor Pro Geo Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
F. Gasch's Sons		Hyattsville, Md.		MAR 6 1968		F. Gasch's Sons					

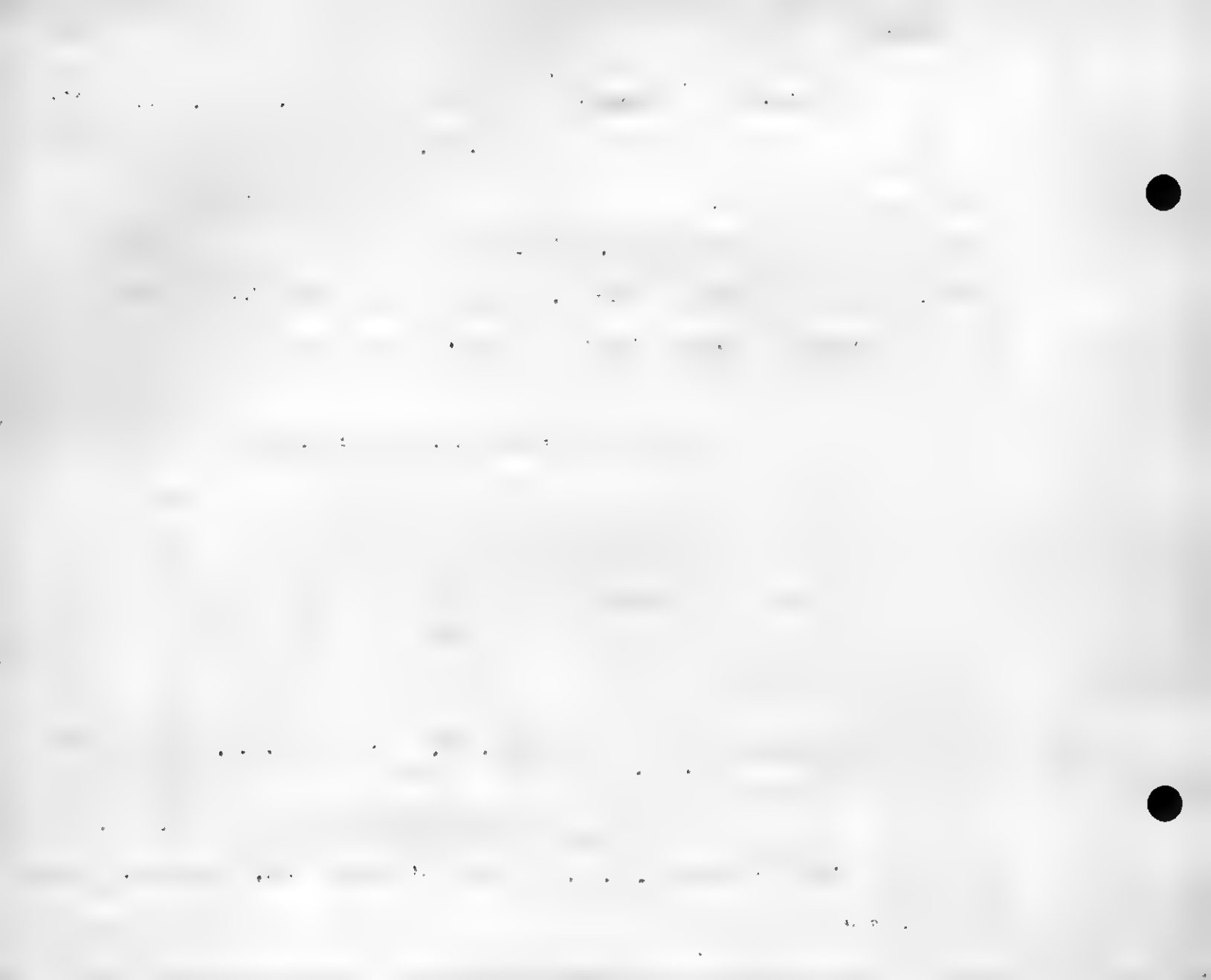




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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last <b>JOHN REGAN Ruddy</b>			2a. DATE OF DEATH Feb. Month 28, Day 1968 Year		2b. HOUR 10:35 P	
3 SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Feb. 28, 1968</b>		6. AGE (In years lost birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>11 30</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Prince Georges</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>6418 Grieg Street</b>			
14 FATHER'S NAME First Middle Last <b>Dennis Regan Ruddy</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Janice Marie Reece</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17 INFORMANT Address <b>HOSPITAL RECORDS</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intrauterine Pneumonia, bilateral, severe</b> <b>4x6x</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>Feb. 28, 1968</b> , to <b>Feb. 28, 1968</b> , that (I) <del>(we)</del> lost saw the deceased alive on <b>Feb. 28, 1968</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> did (did not) view the body after death.									
22b. SIGNATURE <b>BERNARDO ALVARADO</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>March 1, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Bernardo Alvarado, M. D.</b>				22e. ADDRESS <b>6201 Riverdale Road, Riverdale, Maryland</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>2-1-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington DC</b>			
24. FUNERAL DIRECTOR <b>F. J. Collins</b> <b>COLLINS FUNERAL HOME</b>				ADDRESS <b>3821-14th St. N.W. WASH. D.C.</b>		25a. RECORDING REGISTRAR <b>MAK</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR	
Mario Angelo				XXXXXX Ruzza	ESTIMATED		2-29	68	19	4:05pm	
3 SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)	F UNDER 1 YEAR		F UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		
Male	White	1-4-1910		58 YRS	MONTHS		DAYS		Month	Day	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
New York		USA				Prince George's					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Cheverly		Prince George Hospital		Forman Painting		Retail					
13a. USUA. RESIDENCE (Where deceased lived, if institution - Residence before admission)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Prince George		Capitol Heights		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		813 49th. Avenue			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
Mario Ruzza		Laura Guerrini									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS							
No				Marie Ruzza Wife, Same As # 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Laceration of brain</u> DUE TO, OR AS A CONSEQUENCE OF <u>skull fracture</u> (b) <u>Trauma</u> (c) <u>Trauma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION										20. AUTOPSY?	
2-27-68										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
skull fracture											
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH											
21b. TIME OF INJURY Month, Day Year											
10:30 AM 2-26-68											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)											
fell off ladder											
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)											
Client Ford - refuse											
21f. LOCATION Street or R.F.D. No. City or Town County State											
Irham, Prince George's, Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John Kehoe</u> M.D.										22b. DATE SIGNED	
EXAMINER'S NAME (Type) John Kehoe M.D., Riverdale, Maryland										3-2-68	
23a. BURIAL, CREMATION REMOVAL (Specify)											
Burial											
23b. DATE											
3/5/68											
23c. NAME OF CEMETERY OR CREMATORY											
Cedar Hill Cemetery											
23d. LOCATION (City or Town) (County) (State)											
Suitland, Prince Georges, Md.											
24. FUNERAL DIRECTOR ADDRESS											
Robert E. Wilhelm Funeral Home											
4308 Suitland Road, Suitland, Maryland											
25a. REC'D BY REGISTRAR											
DATE MAR 5 1968											
25b. REGISTRAR'S SIGNATURE											
Charles Judge											

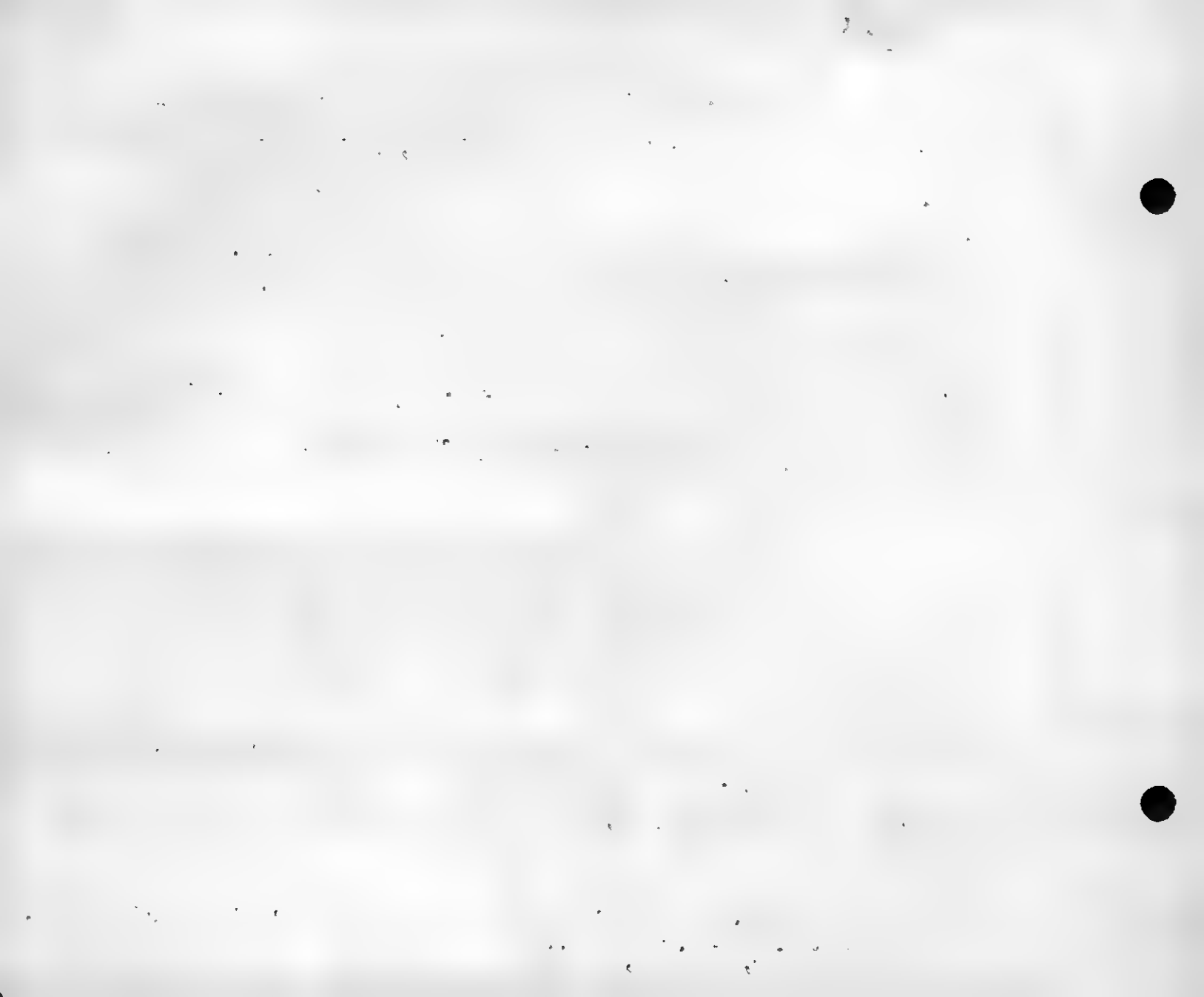


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last GEORGE K. SEITZ			2a. DATE OF DEATH Month Day Year FEBRUARY 20 1968		2b. HOUR 7:15 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH DEC. 29, 1909		6. AGE (in years last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH PRINCE GEORGES		Md	
10. CITY OR TOWN OF DEATH CHEVERLY		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) PRINCE GEORGES HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) STATIONARY ENG.		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. PRINCE GEORGES		13c. CITY OR TOWN CAMP SPRINGS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 5203 BAYNE PLACE	
14. FATHER'S NAME First Middle Last GEORGE SEITZ			15. MOTHER'S MAIDEN NAME First Middle Last MAMIE KHYM						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO		16b. SOCIAL SECURITY NO (If you gave war or dates of service)		17. INFORMANT Address KIASA E. SEITZ, WIFE SAME AS # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Auto coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 5-24, 1956, to 2-20, 1968, that (I) (we) last saw the deceased alive on 2-14-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Robert E. Wilhelm, MD</u> DEGREE						22c. DATE SIGNED 2-20-68			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 2/23/68		23c. NAME OF CEMETERY OR CREMATORY RESURRECTION CEMETERY		23d. LOCATION (City or Town) (County) (State) CLINTON PRINCE GEORGES MD.			
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland						25a. REC'D BY REGISTRAR DATE FEB 26 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

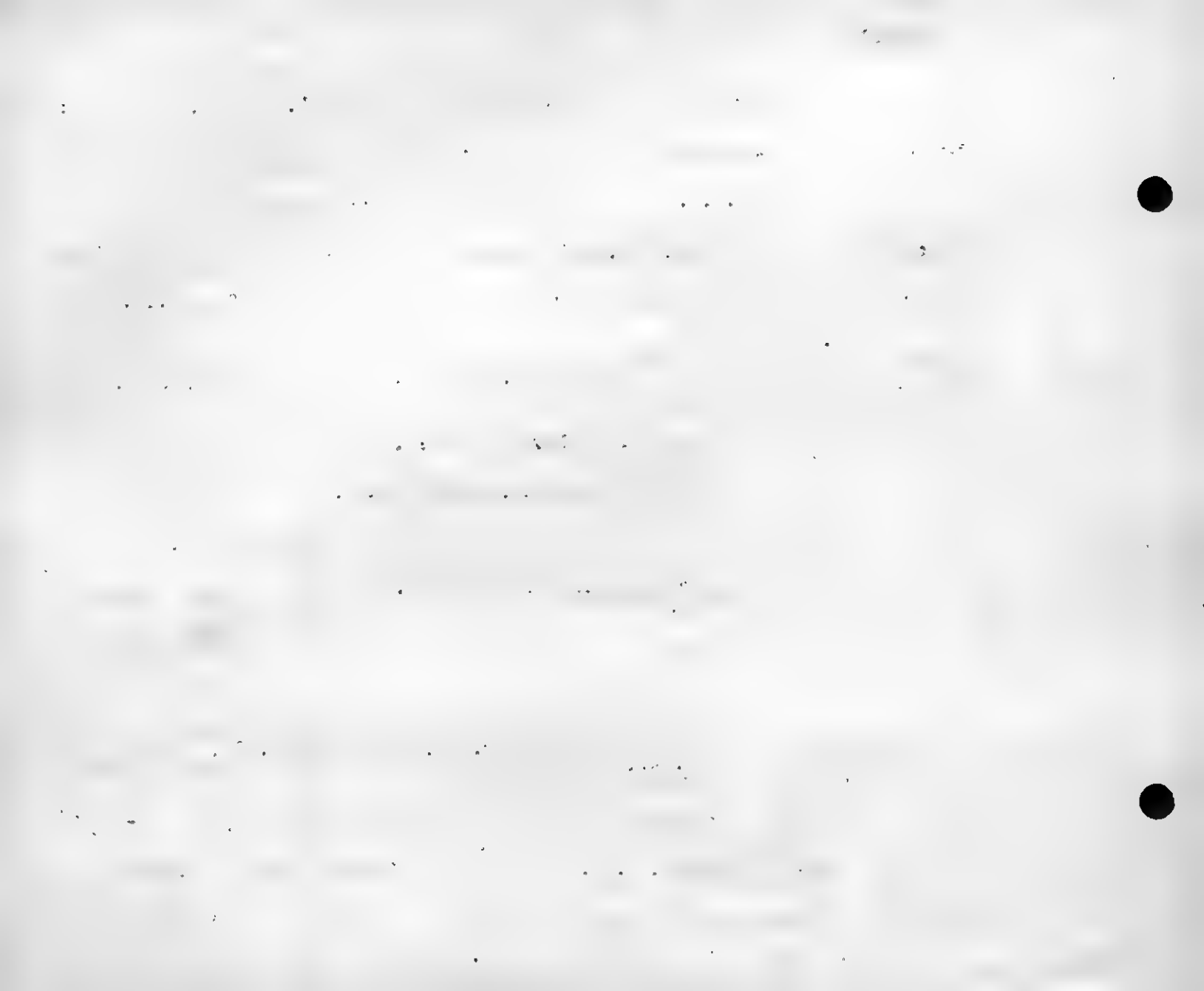


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VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
1. DECEASED-NAME (Type or print) First Middle Last <b>Sharon Simpson</b>					2a. DATE OF DEATH Month Day Year <b>Feb. 27, 1968</b>			2b. HOUR <b>9:53A M</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>9/5/50</b>		6. AGE (In years last birthday) <b>17</b> YRS		7. UNDER 1 YEAR MONTHS DAYS 8. UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.				
10. CITY OR TOWN OF DEATH <b>Cheverly</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before adm.) STATE <b>Maryland</b>			13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Bowie</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>12911 10th St., W.</b>	
14. FATHER'S NAME First Middle Last <b>Jess Childers</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Alice Shipman</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or <u>unknown</u> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Hospital records</b> Address <b>Cheverly, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Multiple Pulmonary Emboli,</b> <b>6047</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Phlebothrombosis, pelvic veins,</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Term Pregnancy, delivered.</b> <b>9700</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (he) (this hospital) attended the deceased from <b>Feb. 24, 1968</b> to <b>Feb. 27, 1968</b> , that (he) (we) lost saw the deceased alive on <b>Feb. 27, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (do not) view the body after death.										
22b. SIGNATURE <b>Hernandez</b>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>2/27/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Tomas Hernandez, M. D.</b>				22e. ADDRESS <b>Prince Georges General Hospital</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>March 1, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington</b>		23d. LOCATION (City or Town) (County) (State) <b>Hyattsville, Pro Geo Md.</b>				
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE MAR 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <sup>First</sup> John <sup>Middle</sup> Duncan <sup>Last</sup> Smith						2a. DATE OF DEATH <sup>Month</sup> February <sup>Day</sup> 18 <sup>Year</sup> 68			2b. HOUR <sup>20</sup> 12 <sup>P.</sup> M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH Oct. 19, 1881		6. AGE (In years lost birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS M. N.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.					
10. CITY OR TOWN OF DEATH Cheverly, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George General		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Superintendent of Roads				12b. KIND OF BUSINESS OR INDUSTRY Prince George Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before adm ssion) STATE Md		13b. COUNTY Prince George		13c. CITY OR TOWN Beltsville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 4812 Wilcomico Ave.			
14. FATHER'S NAME <sup>First</sup> Michael <sup>Middle</sup> <sup>Last</sup> Smith				15. MOTHER'S MAIDEN NAME <sup>First</sup> Lucy <sup>Middle</sup> E. <sup>Last</sup> McCloud							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service)				16b. SOCIAL SECURITY NO. 220 07 7720		17. INFORMANT Ethel P. Smith		4812 Wilcomico Ave Beltsville, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR. BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 1-1, 1968, to 2-18, 1968, that (I) (we) last saw the deceased alive on 2-10-1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>A. R. Deitz</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2-18-68					
22d. PHYSICIAN'S NAME (Type) Aaron Deitz, M. D.				22e. ADDRESS Prince George Plaza Hyattsville, Md.							
23a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		23b. DATE 2/21/68		23c. NAME OF CEMETERY OR <del>REPOSITORY</del> Church St. John's Episcopal		23d. LOCATION (City or Town) Beltsville (County) P.G. (State) Md.					
24. FUNERAL DIRECTOR Francis Gasch's Sons Hyattsville, Maryland				25a. REC'D BY REGISTRAR DATE FEB 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
03087 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Martha			V.		Smith	February 23, 1968			7:13PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Female		White		11/14/02		65 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
VA VIRGINIA		U. S. A				Prince George's Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince Geo. Gen. Hospital			HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Prince Geo. Hillside			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
								1420 51st Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
William Vincent			?			SATTERFIELD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
NO						ALBERT SMITH 1420 51st Ave Hill Side, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immobilization 2 it</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Fracture of rib</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
		HOUR A.M. Magth Day Year		She Fell					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		near home							
22a. I certify that (I) (this hospital) attended the deceased from <u>10 Feb.</u> , 19 <u>68</u> , to <u>23 Feb.</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>23 Feb.</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
<u>Robert Deitz</u>				<u>24 Feb 68</u>					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS		22f. REGISTERAR'S SIGNATURE			
Robert Deitz, M.D.				Prince George's Plaza, Hyattsville, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		12-28-68		VINCENT CEM.		FAIRMONT, WEST VIRGINIA			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W.W. Chambers Co				RIVERDALE, MD.		FEB 27 1968			



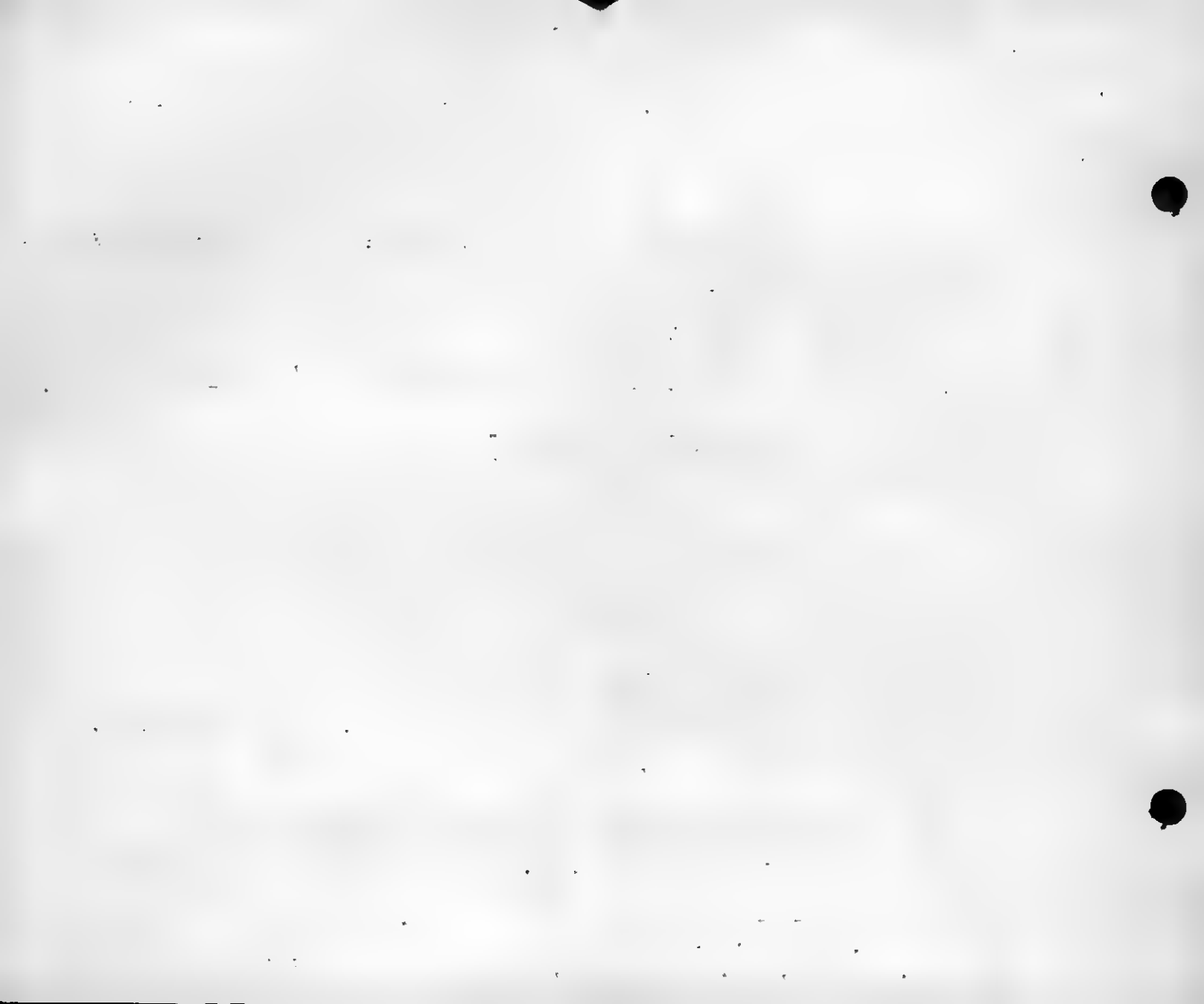
# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. RESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print) <b>Eugene C. Spangler</b>			2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>2</b> Day <b>23</b> Year <b>1968</b>			2b HOUR <b>10am</b>		
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>9-24-1926</b>	6 AGE (In years last birthday) <b>41</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>	2c DATE PRONOUNCED DEAD Month <b>2</b> Day <b>23</b> Year <b>1968</b>		
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Prince George's</b>		
10 CITY OR TOWN OF DEATH <b>Cheverly</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Plant Engineering</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Not Shoppes</b>		
13a USUAL RESIDENCE (Where deceased lived, if not last residence before death) <b>Maryland</b>			13b CITY OR TOWN <b>Silver Spring</b>		13c INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <b>516 Stonington Road</b>	
14 FATHER'S NAME <b>Earl Henry Spangler</b>			15. MOTHER'S MAIDEN NAME <b>Maude Snead</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b SOCIAL SECURITY NO <b>231-14-6190</b>		17. INFORMANT <b>Silver Spring, Maryland</b> <b>Boris Rita Spangler 516-Stonington Rd.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration of brain</b> DUE TO, OR AS A CONSEQUENCE OF <b>Fracture of skull</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>(b) DUE TO, OR AS A CONSEQUENCE OF</b> <b>(c)</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year <b>11:00am 2-15-68</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Fell from ladder to cement floor</b>			
21d INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Hot Shoppe Warehouse</b>		21f LOCATION Street or R.F.D. No <b>5200 Addison Rd., Beaver Heights, Md.</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from <b>Natural causes</b> <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>John Kehoe MD</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <b>2-23-68</b>		
EXAMINER'S NAME (Type) <b>John Kehoe MD Riverdale, Md.</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town or county)		
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>2-26-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>George Washington Cem.</b>		23d LOCATION (City or Town) (County) (State) <b>Adelphi Maryland</b>		
24a FUNERAL DIRECTOR <b>C. Glen Carter 8434 Georgia Avenue</b>				25a REC'D BY REGISTRAR <b>DATE FEB 27 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles J. [Signature]</b>		
Warner E. Pumphrey, Inc. Silver Spring, Maryland								



# FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
John Alexander Sparkes						ESTIMATED <input checked="" type="checkbox"/> 2-22-68 193:00pm			193:00pm
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 MONTHS	8 DAYS	9 HOURS	10 MIN.	2c. DATE PRONOUNCED DEAD	2d. HOUR
Male	White	8-1-1893	74 YRS					2 Month 22 Year 68 193:23pm M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> <del>NOT MARRIED</del>		9. COUNTY OF DEATH			
Canada		USA		<del>MARRIED</del>		Prince George's Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince George Hospital			Carpenter			
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER
Maryland			Prince George			Upper Marlboro		YES <input type="checkbox"/> NO <input type="checkbox"/>	RFD Box 4162
14 FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
John Sparkes			Emma			Penny			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT			ADDRESS
No			578 28 9214			Bertha H. Sparkes			Wash DC 4428-S. Capitol St
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure									minutes
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease									unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			2-23-68
John Kehoe MD			Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town or county)
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)
Cremation			2-24-1968			Cedar Hill Crematory			Suitland, Maryland
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REG. STRAR			25b. REGISTRAR'S SIGNATURE
Simmons Bros.			DC			FEB 26 1968			Charles Judge
Simmons Bros-1661-Good Hope Rd SE Wash									

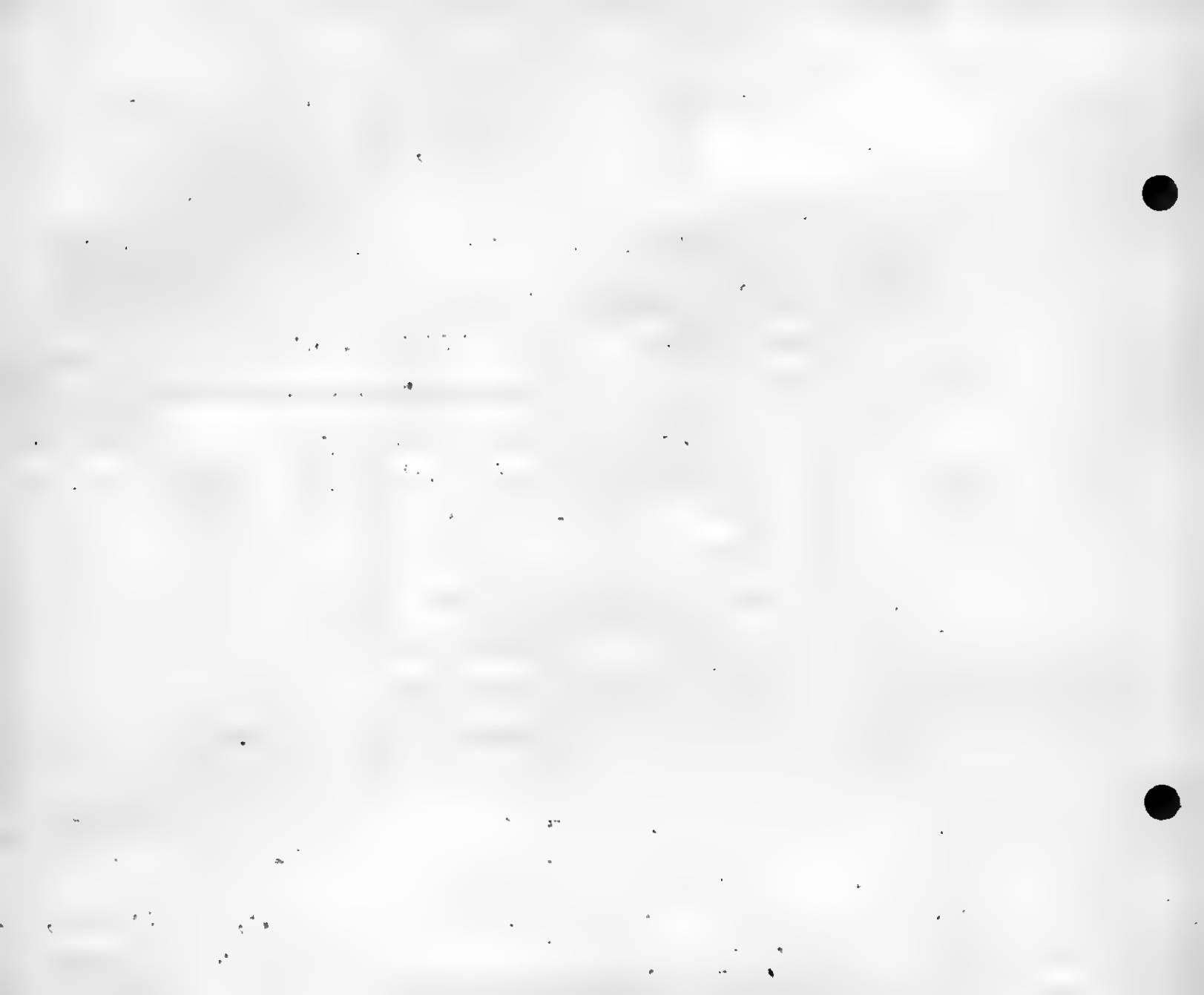




TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
HARRY W. SPEAS						FEBRUARY 17 68		31 P M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		7 IF UNDER 1 YEAR	
MALE		WHITE		JUNE 16, 1924		43 YRS.		MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
NEW JERSEY		USA				PRINCE GEORGES Md.			
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
FRIENDLY		2714 ROSE VALLEY DRIVE		SUPERINTENDENT		CONSTRUCTION			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission)		13b. COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
MARYLAND		PRINCE GEORGES		FRIENDLY		YES <input type="checkbox"/> NO <input type="checkbox"/>		2714 ROSE VALLEY DRIVE	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
HARRY M. SPEAS			MARGARET R. LETTS						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown?		16b. SOCIAL SECURITY NO.		17 INFORMANT		Address			
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		WW 11		DORIS W. SPEAS, WIFE, SAME AS # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic insufficiency</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant melanoma, meta-</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stroke from eye</u>								3 months 2 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
10 Nov 67		Liver mass		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>Nov 11, 1968</u> to <u>17 Feb 68</u> , that (I) (we) last saw the deceased alive on <u>19 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
Richard Kaufman M.D.				17 Feb 68					
22d. PHYSICIAN'S NAME (Type)				22e ADDRESS					
RICHARD M KAUFMAN				916 19th St NW WASH DC					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County) (State)	
Burial		2/20/68		Cedar Hill Cemetery		Suitland, Prince Georges, Md.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert E. Wilhelm Funeral Home				DATE FEB 20 1968		Charles Jones			
4308 Suitland Road, Suitland, Maryland									



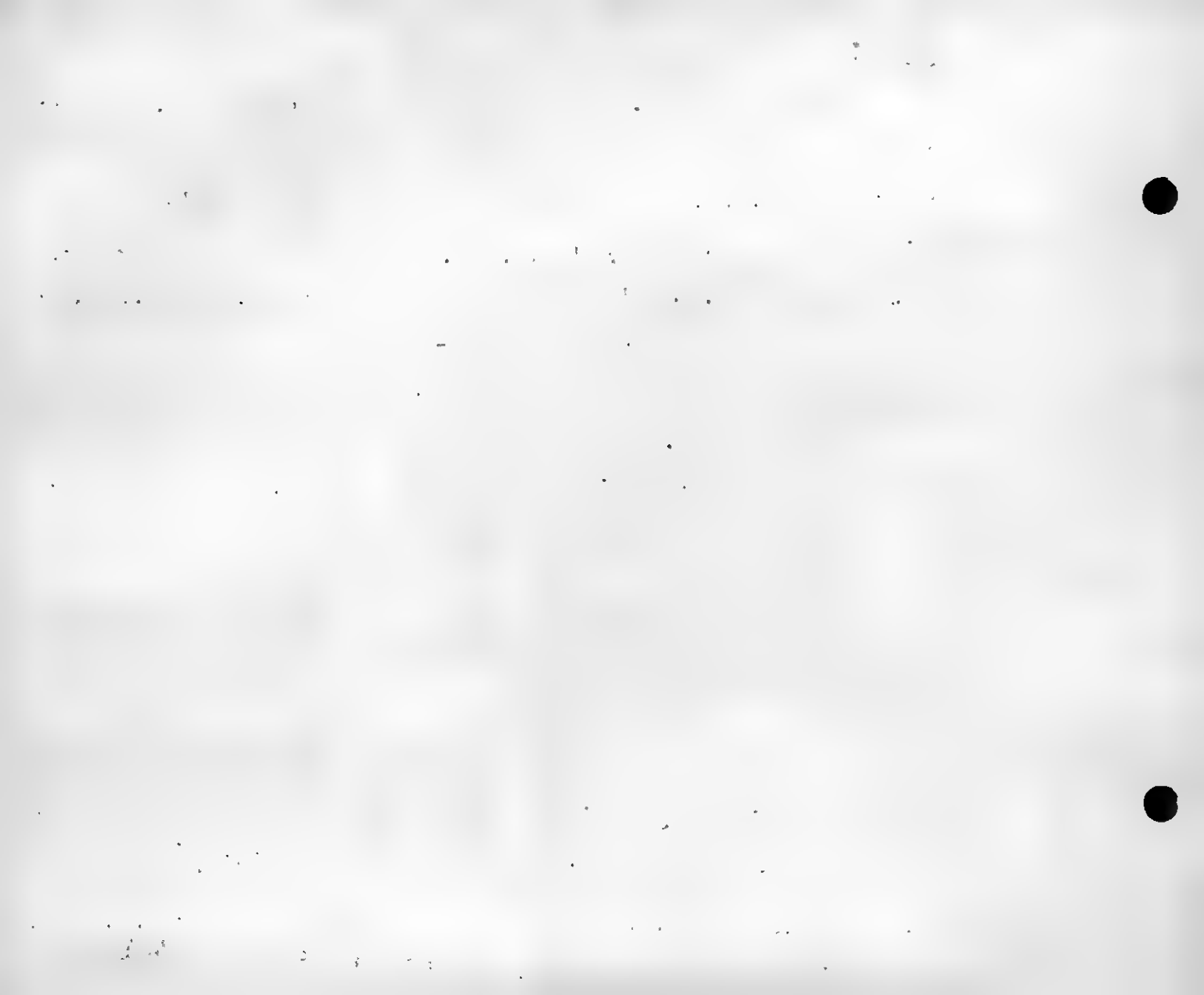
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Samuel S. Steinberg</b>			20. DATE OF DEATH Month <b>February</b> Day <b>10</b> , Year <b>1968</b>		2b. HOUR <b>1:25</b> M
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>9/17/92</b>		6. AGE (In years last birthday) <b>75</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince George's</b> Md.	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's Gen. Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Education</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Pr. George's</b>	13c. CITY OR TOWN <b>Hyattsville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>6700 Belcrest Rd., Apt. 417</b>
14. FATHER'S NAME First <b>Harris</b> Middle <b>Steinberg</b> Last <b>Steinberg</b>		15. MOTHER'S MAIDEN NAME First <b>Ann</b> Middle <b>Smith</b> Last <b>Smith</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>213 14 5861</b>		17. INFORMANT Address <b>Kathryn H. Steinberg same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMATOSIS</b> <b>1538</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ADENOCARCINOMA OF COLON</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c) <b>1532</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b> <b>6 mos</b>
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH, 1967</b> , to <b>2/10</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2/10</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Norman J. Comer</b> M.D.		22c. PHYSICIAN'S NAME (Type) <b>Norman J. Comer</b>		22d. ADDRESS <b>3503 Pennysylvania Ave. N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/13/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>	
23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor P. G. Md.</b>		23e. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>			
24. FUNERAL DIRECTOR <b>Francis Gasch's Sons Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 15 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Phyllis Judge</b>	

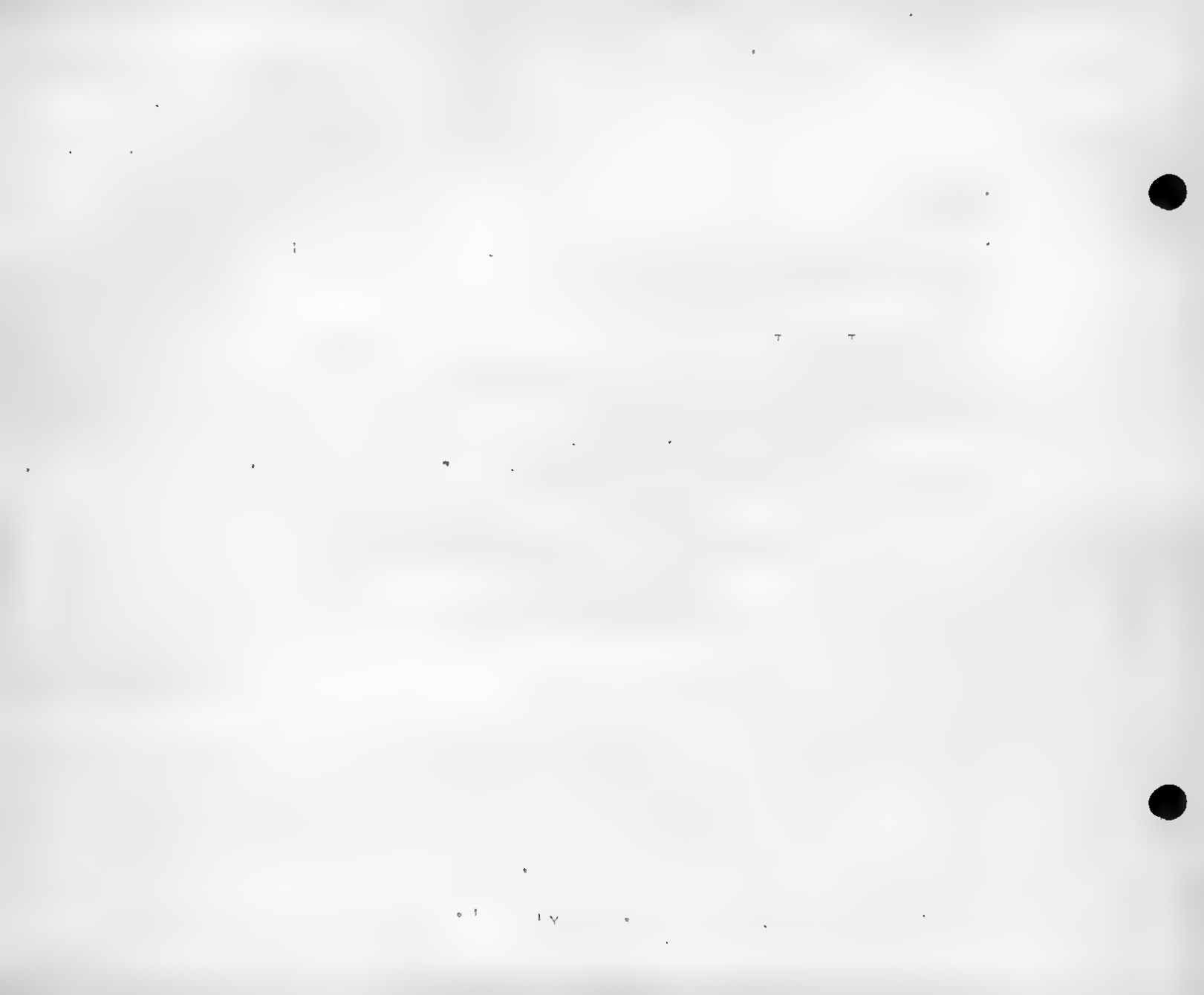


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. See Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR
Maggie Stewart						Month Day Year			2d HOUR
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month Day Year	
Female	Legor	8-15-1898	69 YRS					2 13 68 2:35pm	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
MARYLAND		USA				Prince George's Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USJA. OCCUPATION (Kind of work done during most of working life even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Cheverly			Prince George Hospital			HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE				13b. COUNTY		13c CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
Maryland				Prince George		Brandywine		YES	Box 161
14 FATHER'S NAME First Middle Last				15 MOTHER'S MAIDEN NAME First Middle Last					
ANDREW STEWART				EMMA CLARKE					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16b SOCIAL SECURITY NO NONE		17. INFORMANT ADDRESS HENRY STEWART			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes over 4 yrs.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
MEDICAL CERTIFICATION									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE John Kehoe MD				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 2-14-68	
EXAMINER'S NAME (Type) John Kehoe MD Riverdale, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)			
23a BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b DATE 2/19/68		23c NAME OF CEMETERY OR CREMATORY ST. MARY'S CAT. CHURCH		23d LOCATION (City or Town) UPPER MARLBORO		(County) (State)	
24 FUNERAL DIRECTOR				25a RECD BY REGISTRAR		25b RECD BY REGISTRAR			
John Kehoe MD 14209 55th St. N.W.				DATE FEB 19 1968		FEB 19 1968		FEB 19 1968	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 M

05393

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

33673

# CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Bertha M. Sugar</b>			2a. DATE OF DEATH Month <b>Feb.</b> Day <b>1</b> Year <b>1968</b>			2b. HOUR <b>6:25 P.</b>
3. SEX <b>F</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>08-15-84</b>		6. AGE (In years last birthday) <b>83</b> YRS.	7. UNDER 1 YEAR MONTHS <b>83</b> DAYS <b>83</b>	8. UNDER 24 HRS HOURS <b>83</b> MIN <b>83</b>
7a. BIRTHPLACE (State or foreign country) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. COUNTY OF DEATH <b>Prince George's</b>			Md.			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince George's General</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
13e. STREET AND NUMBER <b>1226 Blair Mill Rd.</b>						
14. FATHER'S NAME First <b>Abraham</b> Middle <b>Deland</b> Last <b></b>			15. MOTHER'S MAIDEN NAME First <b>UNK.</b> Middle <b></b> Last <b></b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Dr. Samuel J. N. Sugar (son)</b>		
				Address <b>6700 Belcrest Rd. Hyatts. Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b>						<b>1 month</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b>						<b>1 month</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Bronchopneumonia, both lungs.</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 1, 1968</b> to <b>Feb 1, 1968</b> , that (I) (we) last saw the deceased alive on <b>Feb 1, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>Samuel J. N. Sugar MD</b>				22c. DATE SIGNED <b>2-1-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>SAMUEL J. N. SUGAR, MD</b>				22e. ADDRESS <b>4637 Eastern Ave. Hyatts. Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2-4-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>National Capital Hebrew Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON, D.C.</b>
24. FUNERAL DIRECTOR <b>Bernard Winkowsky &amp; Son</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Samuel J. N. Sugar</b>
25c. ADDRESS <b>3501-14th St. N.W. - Washington, D.C. 20010</b>						





## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
			Alexander	Sutton	Feb.	23.	1968	7:05A M
3. SEX	4. RACE	5. DATE OF BIRTH			6. AGE (in years lost birthday)		7. UNDER 1 YEAR MONTHS	8. UNDER 24 HRS. DAYS
Male	Negroid	6/23/05			62 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince Georges Md.				
FLORIDA	U.S.A.							
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly	Prince Geo. Gen'l Hospital		Crane Operator			Rigger		
13a. USUAL RESIDENCE (Where deceased admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER				
Maryland	Prince Georges	Chapel Oaks	YES <input type="checkbox"/> NO <input type="checkbox"/>	5626 Addison Road				
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle	Last
UNKNOWN				UNKNOWN				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	17. INFORMANT Address Chancel Oaks, Md			
				ELENORA SUTTON - 5626 Addison Rd. NE (Wife)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebrovascular Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Hypertensive Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF <u>Disease</u> (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		State
22a. I certify that (H) (this hospital) attended the deceased from <u>2/15/68</u> , 19 <u>68</u> , to <u>2/23/68</u> , 1968, that (H) (we) last saw the deceased alive on <u>2/23/68</u> , 19 <u>68</u> and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>William D. Rosson</u>		DEGREE		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>2/23/68</u>		
22d. PHYSICIAN'S NAME (Type) William D. Rosson, M. D.		22e. ADDRESS Prince Georges General Hospital, Cheverly,						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 2/26/68		23c. NAME OF CEMETERY OR CREMATORY CARVER MEMORIAL PARK		23d. LOCATION (City or Town) LAUREL, MD.		(County) Maryland
24. FUNERAL DIRECTOR <u>John J. Phinney &amp; Co.</u>		ADDRESS <u>3015-12th St. N.E.</u>		25a. RECD. BY REGISTRAR DATE <u>FEB 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



## CERTIFICATE OF DEATH

03081

1 PLACE OF DEATH a. COUNTY Prince Georges MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenn Dale (rural)		c. LENGTH OF STAY IN 1b 2 yrs. 7 mos.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Glenn Dale Hospital		d. STREET ADDRESS 2027 11th Street, N.W.	
3. NAME OF DECEASED (Type or print) Clarence J. Thomas		4. DATE OF DEATH Month February Day 6 Year 19 68	
5 SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/19/1888
9. AGE (In years last birthday) yrs 19		IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Thomas		14. MOTHER'S MAIDEN NAME Maria ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO 578-20-3709	
17. INFORMANT Eugene L. Thomas		Address 2027 11th St. N.W.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis DUE TO Perforation of diverticulum of sigmoid colon Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) Pulmonary tuberculosis, far advanced			INTERVAL BETWEEN ONSET AND DEATH 1 week 1 week 2 yr. 9 mo.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/2, 19 65, to 2/6, 19 68, that (I) (we) last saw the deceased alive on 2/6, 19 68, and that death occurred at 4:45 A.M. from causes and on the date stated above.			
22a. SIGNATURE Moe Weiss		22b. DATE SIGNED 2/6/68	
22c. PHYSICIAN'S NAME (Type) Moe Weiss, M.D.		22d. ADDRESS Glenn Dale Hospital Glenn Dale, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 2-10-1968	23c. NAME OF CEMETERY OR CREMATORY Hopewell Memorial	23d. LOCATION (City or Town) (County) (State) Edgewater, Md.
24. FUNERAL DIRECTOR Kearney General Home Crematorium Inc		25a. REC'D BY REGISTRAR DA FEB 8 1968	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

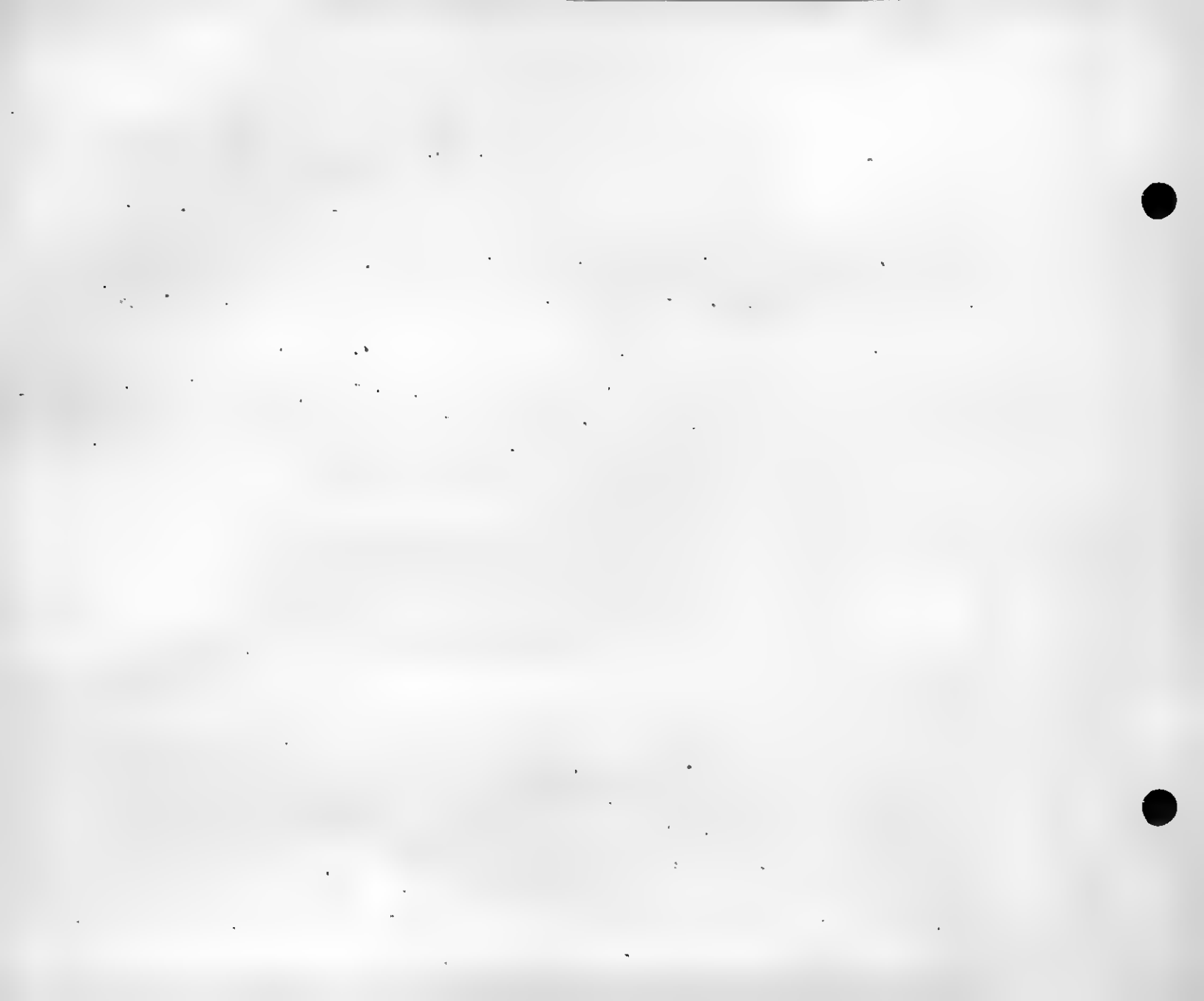
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MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) First Middle Last <i>Lucille E. Thompson</i>						2a. DATE OF DEATH Month Day Year <i>2 4 68</i>			2b. HOUR <i>2:00 PM</i>			
3 SEX <i>Female</i>		4 RACE <i>white</i>		5 DATE OF BIRTH <i>7-29-1886</i>			6 AGE (In years lost birthday) <i>81</i> YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>PRINCE GEORGE</i> Md						
10 CITY OR TOWN OF DEATH <i>HYATTSVILLE</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>CARROLL MANOR-4922 LaSalle</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>DISTRICT OF COLUMBIA</i>				13b COUNTY <i>Washington</i>		13c CITY OR TOWN <i>Washington</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>3650 29th N. N.W.</i>		
14 FATHER'S NAME First Middle Last <i>ADAM Burger</i>				15 MOTHER'S MAIDEN NAME First Middle Last <i>UNKNOWN</i>								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>NO</i> (If yes give war or dates of service)				16b SOCIAL SECURITY NO. <i>577-61-1455 F2</i>		17. INFORMANT Address <i>S. Elizabeth - 4922 LaSalle Rd.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Embolus</i> <i>4/12/7</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>10 years</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 day</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>420</i>												
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept. 1, 1960</i> to <i>Feb. 4, 1968</i> , that (I) (we) last saw the deceased alive on <i>2-4-68</i> 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Thomas F. Collins</i>						DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>2-4-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>THOMAS F. COLLINS</i>						22e. ADDRESS <i>322- H AINE</i>						
23a BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE <i>2-7-68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CEMETERY</i>			23d. LOCATION (City or Town) (County) (State) <i>SUPLAND, P.G., MARYLAND</i>			
24 FUNERAL DIRECTOR <i>JOSEPH GAWLER'S SONS, INC. WASHINGTON, DC</i>						25a. REC'D BY REGISTRAR <i>DATE FEB 8 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

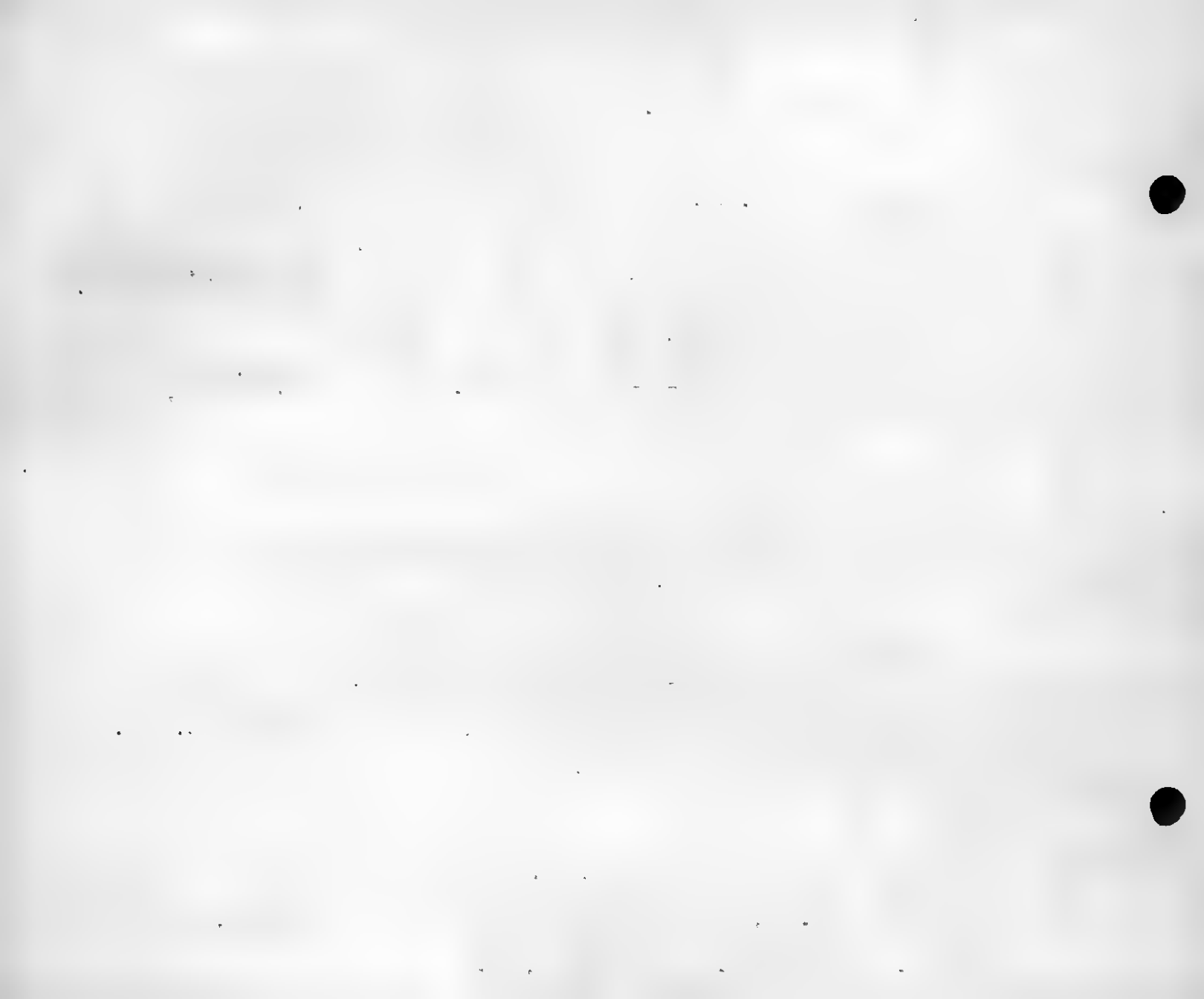


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Susan U. Trainor						Month Day Year		2d HOUR	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d HOUR	
Female	White	11 March 1874	93 YRS	MONTHS	DAYS	Month Day Year		2d HOUR	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md	
Indiana		U.S.A.				Prince George's			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Hyattsville			Hyattsville Nursing Home			Housewife		Own home	
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland			Montgomery			Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e. STREET AND NUMBER			
Andrew Jackson Vest			Juline Parsons			6 Sunnyside Road			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17 INFORMANT		ADDRESS	
no			219-54-9342			Harry J. Trainor		Silver Spring, Maryland	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Heart failure</u>									minutes
DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic heart disease</u>									over 2 yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) <u>DUE TO, OR AS A CONSEQUENCE OF</u>									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<u>Fracture of left femur</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			
1-20-67			Fracture of left femur			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			am P.M. 1-19- 19 67			Fell at Woodlawn Nursing Home			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town	
			Woodlawn Nursing Home			Silver Springs, Montgomery Co., Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
<u>John Kehoe</u>			John Kehoe MD Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		2-12-68	
23a. BURIAL, CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			Feb. 13, 1968		Parklawn Cemetery		Rockville, Maryland		
24. FUNERAL DIRECTOR			25a. REC'D BY REG. STRAR			25b. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc.			8434 Georgia Avenue Silver Spring, Md.						

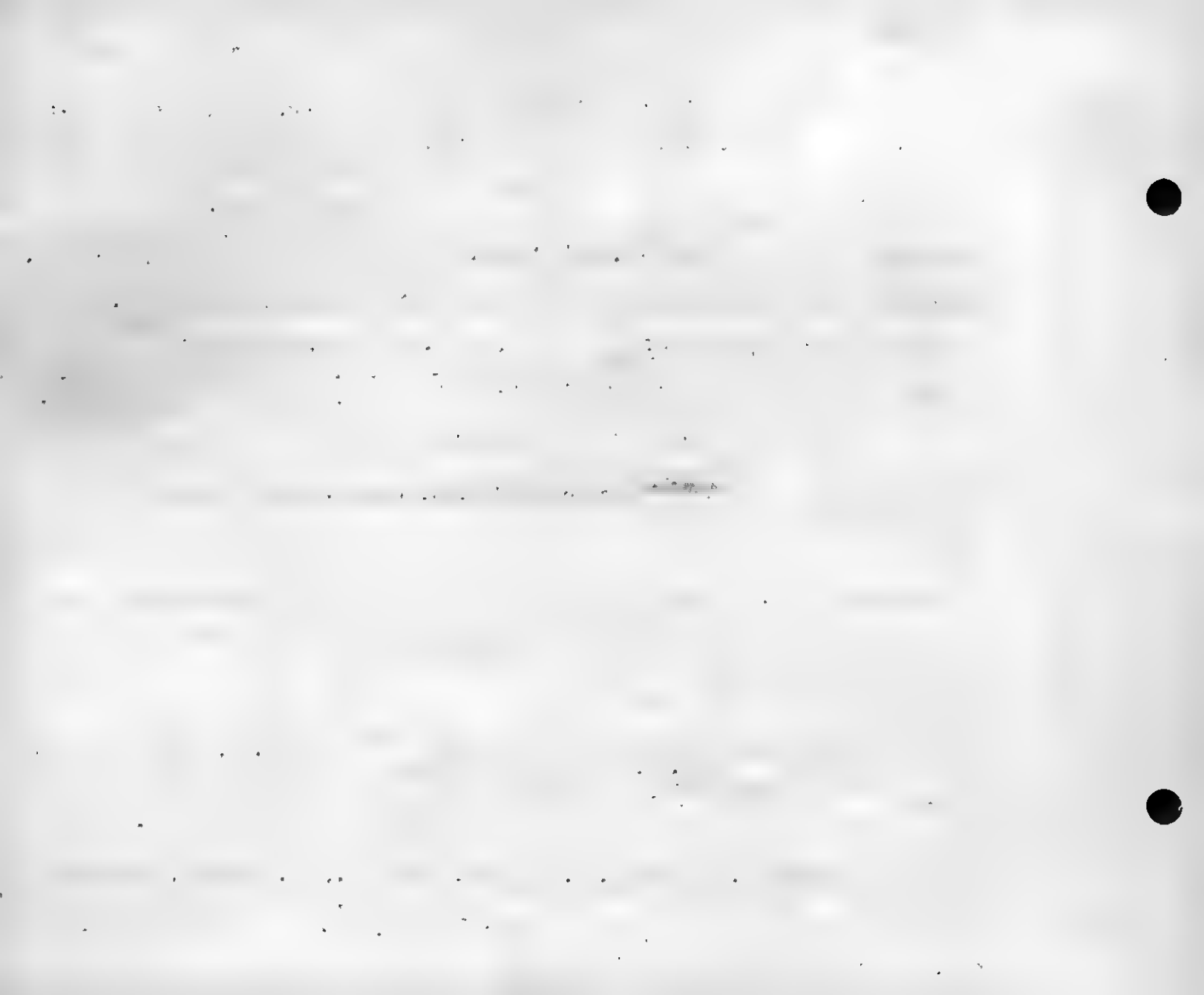




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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
Ernest EDWIN Travis						Feb. 9, 1968		10:42 A	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER YEAR	
Male		Caucasian		9/7/18		49 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
OHIO		U.S.				Prince Georges Md.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly		Prince Geo. Gen'l Hospital		INSPECTOR		WASHINGTON STATE COMM.			
13a U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, AM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland		Prince Georges		Hyattsville				3903 Longfellow St.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
WESLEY TRAVIS			B. ELSIE LEVERMANN						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)		16b SOCIAL SECURITY NO.		17 INFORMANT		Address			
NO		578169278		MRS. HELEN JONES		4116 STREET MT. RAINIER, MARYLAND			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cancer of the Esophagus;</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) <u>Bronchopneumonia of right lung with lung abscess</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
		HOUR A.M. Month Day Year P.M. 19							
21d INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State	
While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>1948</u> , 19 <u>  </u> , to <u>Feb. 9, 1968</u> , that (I) <del>(was)</del> last saw the deceased alive on <u>Feb. 9, 1968</u> , and that in (my) <del>(own)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(not)</del> view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
<u>Benjamin S. Miller M.D.</u>				Feb. 9, 1968					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Benjamin S. Miller, M. D.				3824-34th St., Mt. Rainier, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		13 FEB 1968		FORT LINCOLN CEM		POLMAR MANOR, MD.			
24. FUNERAL DIRECTOR				25a. REG'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W.W. CHAMBERS CO. RIVERDALE, MD				FEB 13 1968					

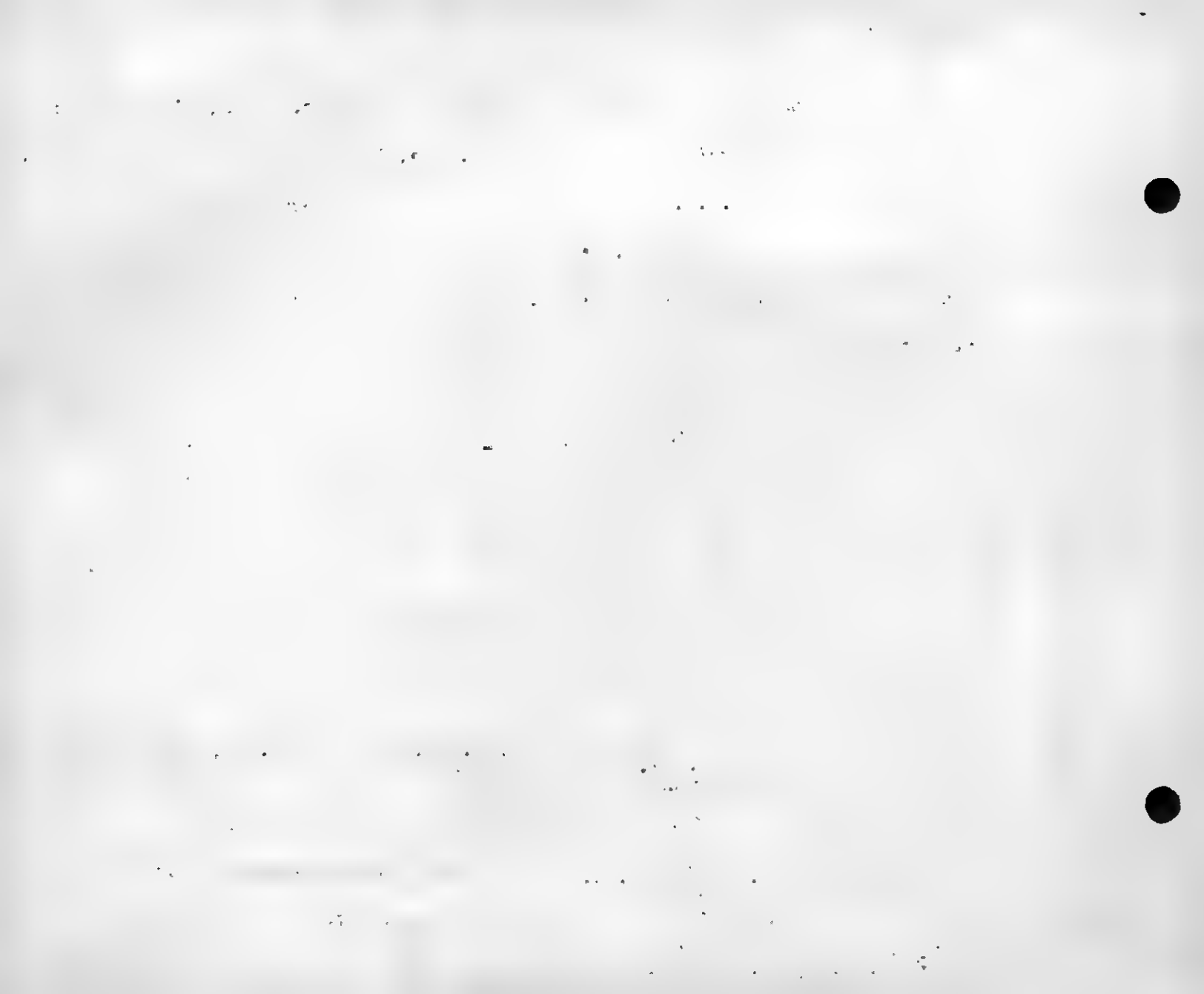


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VR A15 M  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
Baby Girl Turner						Feb. 25, 1968		10:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		Negroid		Feb. 25, 1968		YRS.		14 20	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Prince Georges Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly		Prince Geo. Gen'l Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Prince Georges		Upper Marlboro		YES <input type="checkbox"/> NO <input type="checkbox"/>		RFD Box 1469	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Turhan Datcher			Audrey Turner						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (H) (this hospital) attended the deceased from <u>Feb. 25, 1968</u> , to <u>Feb. 25, 1968</u> , that (H) (we) last saw the deceased alive on <u>Feb. 25, 1968</u> , and that in (H) (our) opinion death occurred on the date and hour and from the causes stated above, (H) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John H. Moling, M.D.</u>					22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (Type) <u>John H. Moling, M.D.</u>					22e. ADDRESS <u>Prince Georges General Hospital</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>3/2/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Prince Geo. General Hosp.</u>		23d. LOCATION (City or Town) (County) (State) <u>Cheverly, Maryland</u>			
24. FUNERAL DIRECTOR <u>Harry W. Peim, Jr., Administrator</u>					25a. REC'D BY REGISTRAR <u>MAR 11 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. [Signature]</u>		



## CERTIFICATE OF DEATH

03130

1 DECEASED-NAME (Type or print) <b>CASSIE J TURNER</b>			2a. DATE OF DEATH Month <b>2</b> Day <b>27</b> Year <b>88</b>			2b. HOUR <b>9:45</b> M				
3 SEX <b>F</b>		4. RACE <b>C</b>		5. DATE OF BIRTH <b>3-14-88</b>		6. AGE (In years last birthday) <b>79</b> YRS		IF UNDER 1 YEAR MONTHS <b>79</b> DAYS <b>79</b>		
7a. BIRTHPLACE (State or foreign country) <b>MD.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>PRINCE GEORGE'S</b> Md				
10. CITY OR TOWN OF DEATH <b>CLINTON MD.</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CLINTON COMMUNITY</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MD.</b>			13b. COUNTY <b>CHARLES</b>		13c. CITY OR TOWN <b>WELCH</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>FIRSTOWER Rd.</b>	
14 FATHER'S NAME First Middle Last <b>not stated</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>CATHERINE TURNER</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17 INFORMANT <b>Ruth Garner - Box 26, Firetower Rd</b>			Address <b>Welch, Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>GENERAL VISCERAL FAILURE 1 MO</b> 4-0-1 DUE TO, OR AS A CONSEQUENCE OF (b) <b>CEREBRO-VASC. ACCIDENT 1 MO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>GENERALIZED ARTERIO SCLEROSIS &gt; 1 YR.</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>201X</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>2-13</b> , 19 <b>88</b> , to <b>2-27</b> , 19 <b>88</b> that (I) (we) last saw the deceased alive on <b>2-27</b> , 19 <b>88</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Charles J. Judge</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>2/27/88</b>		
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>3-2--68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Church Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Hilltop, Maryland</b>		
24 FUNERAL DIRECTOR <b>John T Rhines Company Funeral Home</b>						25a. REC'D BY REGISTRAR <b>MAR 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED NAME (Type or print) <u>Ulmer Pearl</u>						2a. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>68</u>			2b. HOUR <u>5:00</u> AM			
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH <u>12-9-83</u>			6. AGE (In years last birthday) <u>84</u> YRS.		IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u>		IF UNDER 24 HRS. HOURS <u>  </u> MIN. <u>  </u>	
7a. BIRTHPLACE (State or foreign country) <u>Missouri</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Prince George</u> Md.						
10. CITY OR TOWN OF DEATH <u>Riverdale</u>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Leland Memorial Hosp.</u>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution on; Residence before admission) STATE <u>Md.</u>				13b. COUNTY <u>PG</u>		13c. CITY OR TOWN <u>Hyatts.</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>1001 Chillum Rd.</u>		
14. FATHER'S NAME First <u>Morris</u> Middle <u>  </u> Last <u>Cohen</u>						15. MOTHER'S MAIDEN NAME First <u>  </u> Middle <u>  </u> Last <u>  </u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)				16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT <u>Hospital Record</u> Address <u>  </u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis &amp; Left Hemiplegia</u>												
DUE TO, OR AS A CONSEQUENCE OF <u>Arteriosclerotic Hypertensive Cerebral Vascular Disease</u>												
DUE TO, OR AS A CONSEQUENCE OF <u>  </u> (c) <u>  </u>												
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Diabetes Mellitus</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u> P.M. <u>  </u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. <u>  </u>		City or Town <u>  </u>		County <u>  </u>		State <u>  </u>		
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 15, 1968</u> , to <u>Feb. 17, 1968</u> , that (I) (we) last saw the deceased alive on <u>Feb. 17, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>W. L. Etienne</u>		DEGREE <u>  </u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>2/17/68</u>								
22d. PHYSICIAN'S NAME (Type) <u>W. L. Etienne</u>		22e. ADDRESS <u>Collyer Park Apt</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb. 19, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hyattsville, Maryland</u>						
24. FUNERAL DIRECTOR <u>Donald M. Stein Heb.</u> ADDRESS <u>232 Carroll</u>						25a. REC'D BY REGISTRAR <u>FEB 20 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				
Memorial Funeral Home St., N.W., Washington, D.C.												





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03102

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <b>EDITH M WALSTROM</b>			2a DATE OF DEATH Month Day Year <b>2 4 68</b>		2b HOUR <b>2:45 A M</b>
3 SEX <b>F</b>	4 RACE <b>CAUCASIAN</b>	5 DATE OF BIRTH <b>AUG 3, 1882</b>		6 AGE (In years last birthday) <b>85</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a BIRTHPLACE (State or foreign country) <b>FINLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>PRINCE GEORGES</b>		
10. CITY OR TOWN OF DEATH <b>HYATTSVILLE</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>HYATTSVILLE NURSING HOME</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEKEEPER - COOK</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>SAME</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MD.</b>	13b COUNTY <b>PR. GEORGES</b>	13c CITY OR TOWN <b>TAKOMA PK</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>816 LARCH AVE.</b>	
14. FATHER'S NAME First Middle Last <b>MATTHEW HADEN</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>CAROLINE UHUA</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b>	16b. SOCIAL SECURITY NO (If yes give war or dates of service)	17 INFORMANT Address <b>MRS HAZEL W. DIAMOND (SAME AS # 13)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Coronary artery Disease</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>10 hrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Extreme Semility, Dehydration</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year <b>19</b>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>7-22, 1967</b> , to <b>2-4, 1968</b> , that (I) (we) last saw the deceased alive on <b>2-3, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>John L Ford MD</b>		DEGREE	ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED <b>2/4/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>JOHN L. FORD MD</b>		22e. ADDRESS <b>831 UNIVERSITY BLVD. SILVER SPRING MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>	23b. DATE <b>FEB 6, 1968</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Calver Manor Pr. G. Md</b>		
24. FUNERAL DIRECTOR <b>Robert Walter</b>	ADDRESS <b>254 Carroll Rd. N.W. Wash. D.C.</b>	25a. RECEIVED BY REGISTRAR <b>FEB 7 1968</b>	25b. REGISTRAR'S SIGNATURE <b>William J. Jones</b>		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOJR		
Bernard Elmandius Ward						Month Day Year			2-13-68 19 1:00am		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	7. UNDER 24 MONTHS	8. UNDER 24 HRS	2c. DATE PRONOUNCED DEAD			2d. HOUR		
Male	Negro	10 Feb. 1929	38 YRS			Month Day Year			2 13 68 19 5:16am		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Washington, D.C.			USA			Prince George's			Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cheverly			Prince George Hospital			Truck driver					
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Maryland			Prince George's			Fairmont Heights			509 Eastern Avenue		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		
Bernard Ward			Margaret								
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b) and (c))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Mrs. Inece Ward						PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema			minutes		
						DUE TO, OR AS A CONSEQUENCE OF Hypertensive cardio vascular disease			unknown		
						DUE TO, OR AS A CONSEQUENCE OF					
						PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			ASS STANT MEDICAL EXAMINER			22b. DATE SIGNED		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER			ADDRESS (Street, city, town or county)			2-14-68		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
Burial			2/16/68			Harmony Memorial Park			Maryland		
24. FUNERAL DIRECTOR			25a. REC'D BY REG. STR.			25b. REGISTRAR'S SIGNATURE					
Stewart Funeral Home			4001 Benning Rd.			N. FEB 19 1968					



# CERTIFICATE OF DEATH

33682

1. PLACE OF DEATH a. COUNTY <b>Prince Georges</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>D.C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Glenn Dale (rural)</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Glenn Dale Hospital</b>				d. STREET ADDRESS <b>1326 19th Street, N.W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Charles A. Warren</b>			4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>1968</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/27/1985</b>		9. AGE (In years last birthday) <b>82</b> yrs	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>577-03-5554A</b>		17. INFORMANT <b>Decedent</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Septicemia with bronchopneumonia possibly due to pseudomonas</b> DUE TO (b) <b>Infected burns of right hand, body and legs</b> DUE TO (c) <b>1 month</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pulmonary tuberculosis; generalized arteriosclerosis, marked</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>Accidental fire, allegedly started while smoking in bed.</b>					
20c. TIME OF INJURY Month, Day, Year <b>? Hour a.m. Dec 30 1967 p.m.</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>1326 19th St. NW Wash. D.C.</b>		
21. I certify that (I) (this hospital) attended the deceased from <b>2/27</b> , 19 <b>68</b> , to <b>2/3</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>2/3</b> , 19 <b>68</b> , and that death occurred at <b>1:00 PM</b> , from causes and on the date stated above							
22a. SIGNATURE <b>Moe Weiss</b>		M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED <b>2/3/68</b>			
22c. PHYSICIAN'S NAME (Type) <b>Moe Weiss, M.D.</b>		22d. ADDRESS <b>Glenn Dale Hospital Glenn Dale, Maryland</b>					
23a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>2-6-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln</b>		23d. LOCATION (City or Town) (County) (State) <b>Glenn Dale, Prince Georges Md.</b>			
24. FUNERAL DIRECTOR <b>JOS. GAWLERS SONS</b>		25a. REC'D BY REGISTRAR <b>WASH. D.C. 20006</b>		25b. REGISTRAR'S SIGNATURE <b>FEB 8 1968</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper (pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



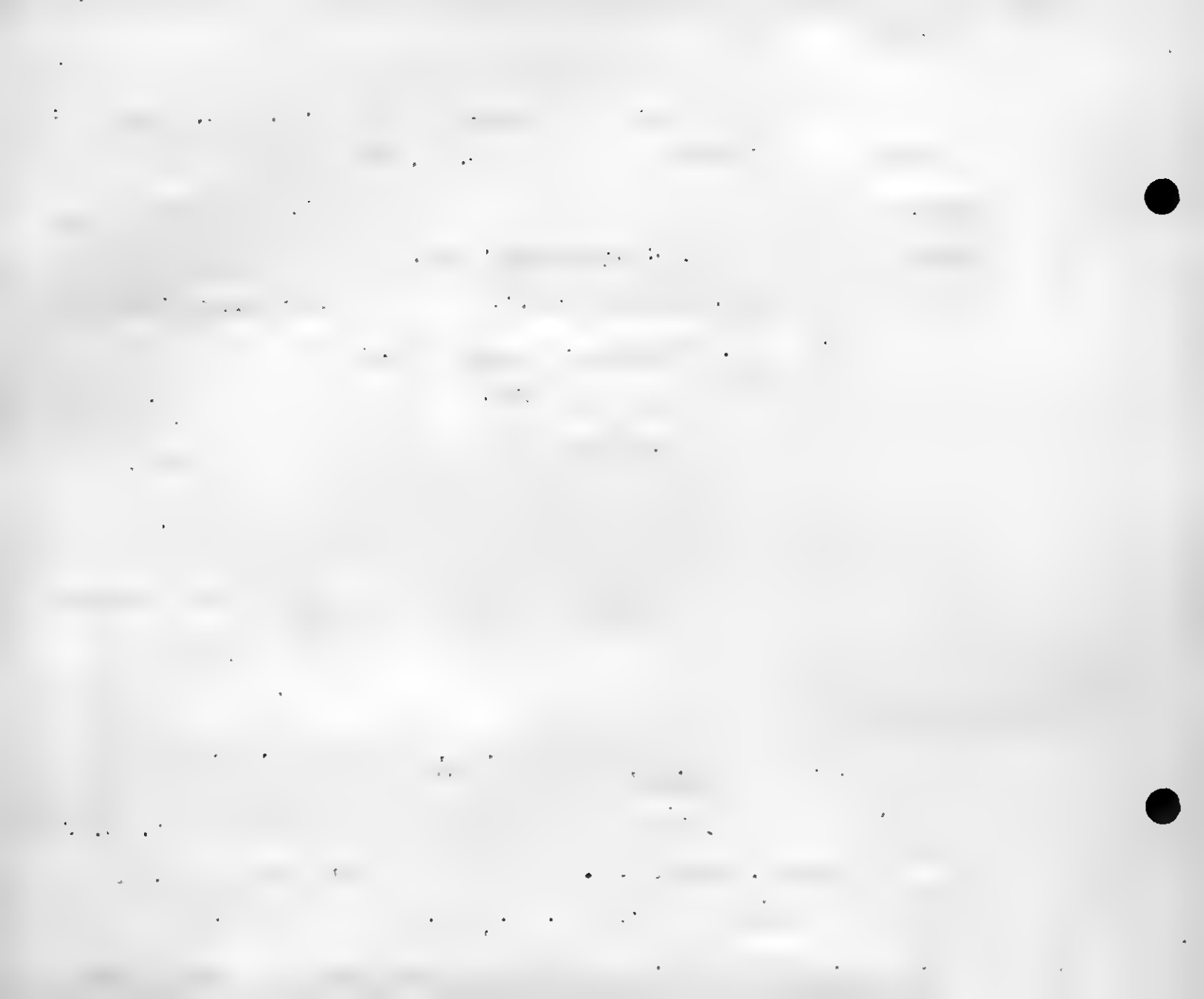
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03105

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Baby Girl Washington</b>			2a. DATE OF DEATH Month Day Year <b>Feb. 13, 1968</b>			2b. HOUR <b>4:10AM</b>	
3. SEX <b>Female</b>		4. RACE <b>Negroid</b>		5. DATE OF BIRTH <b>Feb. 13, 1968</b>		6. AGE (In years last birthday) YRS. MONTHS DAYS <b>4 10</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.	
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Georges General Hosp.</b>		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Wash. SE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>Frank W. Washington</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Gail Crawford</b>		13e. STREET AND NUMBER <b>2909 Nelson Place, SE</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		16b. SOCIAL SECURITY NO (If yes give war or dates of service)		17. INFORMANT Address <b>Mother</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Prematurity</b> <b>777X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) <b>777X</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from <b>Feb. 13, 1968</b> , to <b>Feb. 13, 1968</b> , that (X) (we) lost saw the deceased alive on <b>Feb. 13, 1968</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.							
22b. SIGNATURE <i>John H. Moling</i> DEGREE				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Feb. 13, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>John H. Moling, M. D.</b>				22e. ADDRESS <b>Prince George's General Hospital</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>3/2/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hosp.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cheverly, Md.</b>	
24. FUNERAL DIRECTOR <i>William A. Parker</i> Assoc. Administrator				25a. REC'D BY REGISTRAR <b>MAR 11 1968</b>		25b. REGISTRAR'S SIGNATURE <i>William A. Parker</i>	



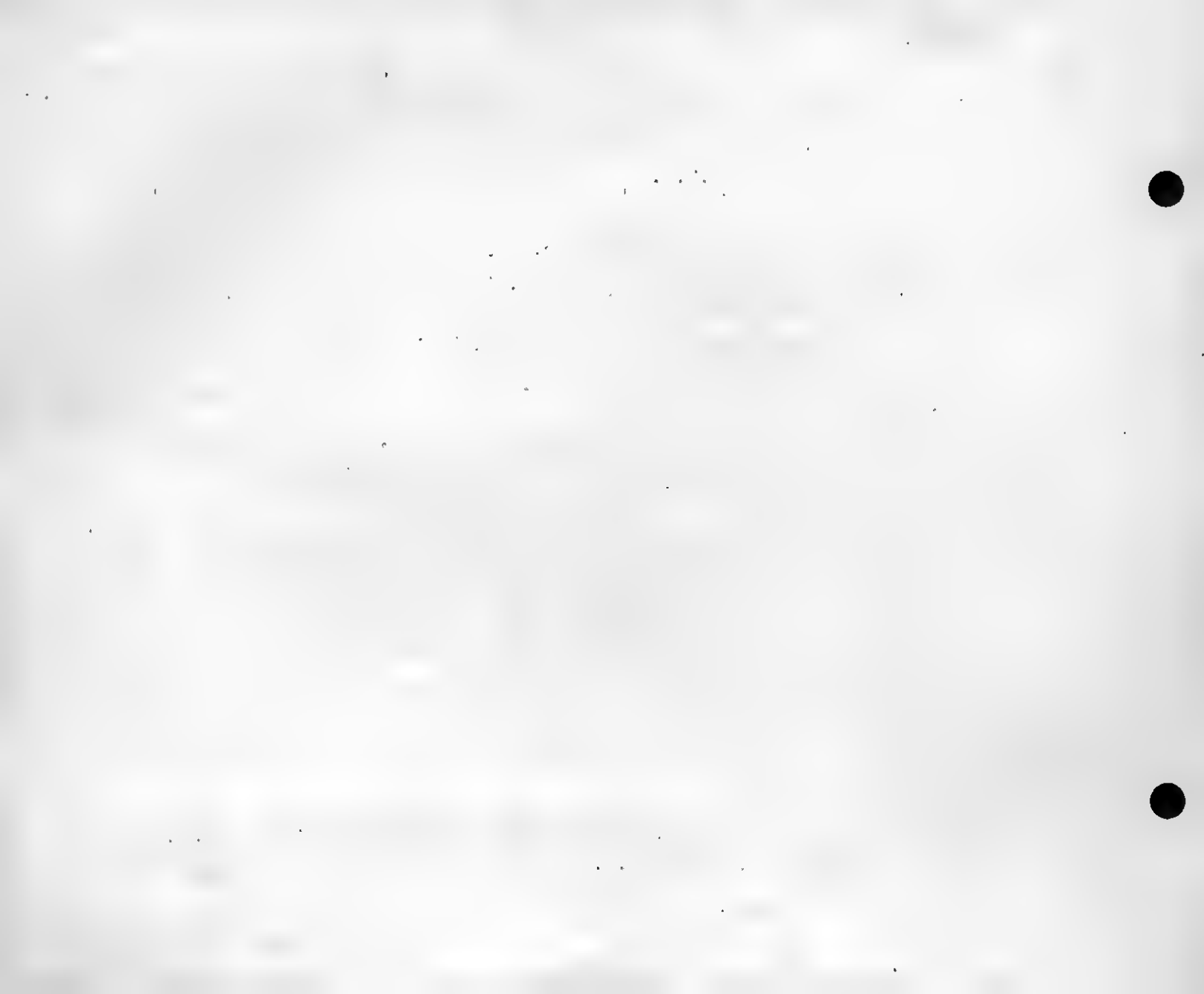


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF ESTI- DEATH: MATED		2b HOUR	
Noah Francis Washington						2/15/68 19		2:30 PM	
3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER YEAR MONTHS	8 UNDER 24 HRS DAYS	2c DATE PRONOUNCED DEAD		2d HOUR	
Male	Negro	4/10/1910	57 YRS			Month 2 Day 15 Year 68 19		M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH			
Maryland		Prince George's				Prince George's Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
			Prince Geo. Gen. Hospital			Tanner			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY			13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Prince Geo.			YES <input type="checkbox"/> NO <input type="checkbox"/>		State Rt. I, Box 331	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
John Washington			Gladys Curtis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS	
			217-16-4673			Gladys Washington		Aguasca, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Thrombotic occlusion, acute, right and left									
DUE TO, OR AS A CONSEQUENCE OF coronary arteries.									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive coronary arteriosclerotic									
DUE TO, OR AS A CONSEQUENCE OF heart disease									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
T 3-1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			
None			None			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A M P.M.			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			19			None			
22a INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			22b PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			22c LOCATION Street or R.F.D. No City or Town County State			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)			Acting			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Feb. 16, 1968	
Cornelius J. Burns, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
						ADDRESS (Street, city, town, or county)		Cheverly, Maryland	
23a BURIAL, CREMATION, or other disposition			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)
Burial			2-19-68			St. Peter's Ch. Cemetery			Waldorf, Chas. Co. Md.
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REG. STAFF		25b REGISTRAR'S SIGNATURE	
Martell Adams			Aguasca, Md.			DATE FEB 21 1968		Charles Jones	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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Items 1 & 22a Film 399 MARYLAND STATE DEPARTMENT OF HEALTH  
4-8-68 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH			2b HOUR	
William Stephen Washington						ESTIMATED DATE MATED 2-22-68			194:00am M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD		2d HOUR
Male	Negro	5-19-1918	49 YRS					Month 2 Day 22 Year 68		12:10pm
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
South Carolina		USA				Prince George's Md				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Hospital			None				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland			Prince George			Chapel Oaks		YES <input type="checkbox"/> NO <input type="checkbox"/>		504 62nd. Ave. Apt. A
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last							
James			Georgia Stevens							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			17c	
						Georgia Brown-mother-504 62nd Ave.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <u>Heart failure</u>										
DUE TO, OR AS A CONSEQUENCE OF										
4129 (b) <u>Arteriosclerotic heart disease</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
4200										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?					20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County State	
22a I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED				
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			2-23-68				
John Kehoe MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)				
Riverdale, Md.										
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or town) (County) (State)				
Burial		2/26/68		Lincoln Memorial		Maryland				
24. FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
John T. Stewart Jr			FEB 29 1968			Stewart Funeral Home-4001 Benning Rd., N.E.				



# FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 100-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month Day Year		2b HOUR	
Ruth Irene Waters						2-7-68 19 10:00am			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 24 HRS MONTHS DAYS	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	2c DATE PRONOUNCED DEAD Month Day Year		2d HOUR	
Female	Negro	6-29-1910	57 YRS			2 7 68 19 10:30am			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		9 COUNTY OF DEATH					
Washington, DC		USA		Prince George's Md.					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Hospital						
13a USJA RESIDENCE (Where deceased lived, if institution Residence before address on STATE)			13b CITY OR TOWN		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland Prince George Seat Pleasant							5207 Addison Road		
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Ahney VOTT			ANNIE						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO.		17 INFORMANT ADDRESS				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease Over 1 yr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4202 (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes - over 5 yrs.									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
2d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or RFD No City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EXAMINER'S NAME (Type) John K. Koe MD Riverdale, Md.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			2-7-68			
23a BURYAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)		
					Mt Hope Church Cem.		Ironside - Charles Co Md		
24 FUNERAL DIRECTOR			ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
Johnson + Jenkins			4804 Isa Ave NW - DC		FEB 13 1968		Judge		



FOR STATE  
HEALTH DEPT.

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jwb

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First	Middle	Last	2a DATE KNOWN OF DEATH		Month	Day	Year	2b HOUR
Francis Lee Wheelock						ESTIMATED <input checked="" type="checkbox"/> 2-5-68		19	10	30am	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE, in years (last birthday)	7 UNDER 24 HRS	8 MONTHS	9 DAYS	10 HOURS	11 MIN	2c DATE PRONOUNCED DEAD		2d HOUR
Male	White	4-24-1917	50 YRS						Month	Day	Year
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH					
New York		U. S. A.				Prince George's		Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hyattsville			5809 31st. Place			Switchman			C. & P. Tele.		
13a USUAL RESIDENCE (Where deceased lived, if institution on Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS?		
Md.			Prince George's			Hyattsville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Frank J Wheelock			Ruby L House								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			ADDRESS		
yes			W W 11			122 10 6501			Ethel I. Wheelock		
									W Hyattsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Asphyxiation											
953 X DUE TO, OR AS A CONSEQUENCE OF Hanging											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
414 X											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
				10:30am 2-5- 19 68							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State			
				Basement of home				same as #13			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				2-6-68			
John Kehoe				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
				ADDRESS (Street, city, town, or county)							
23a BURIAL, CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		Feb 8, 1968		Baltimore National Cemetery		Baltimore, Md.					
24. FUNERAL DIRECTOR				25a REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE			
F. Gasch's Sons				Hyattsville, Md.				FEB 9 1968			
								[Signature]			



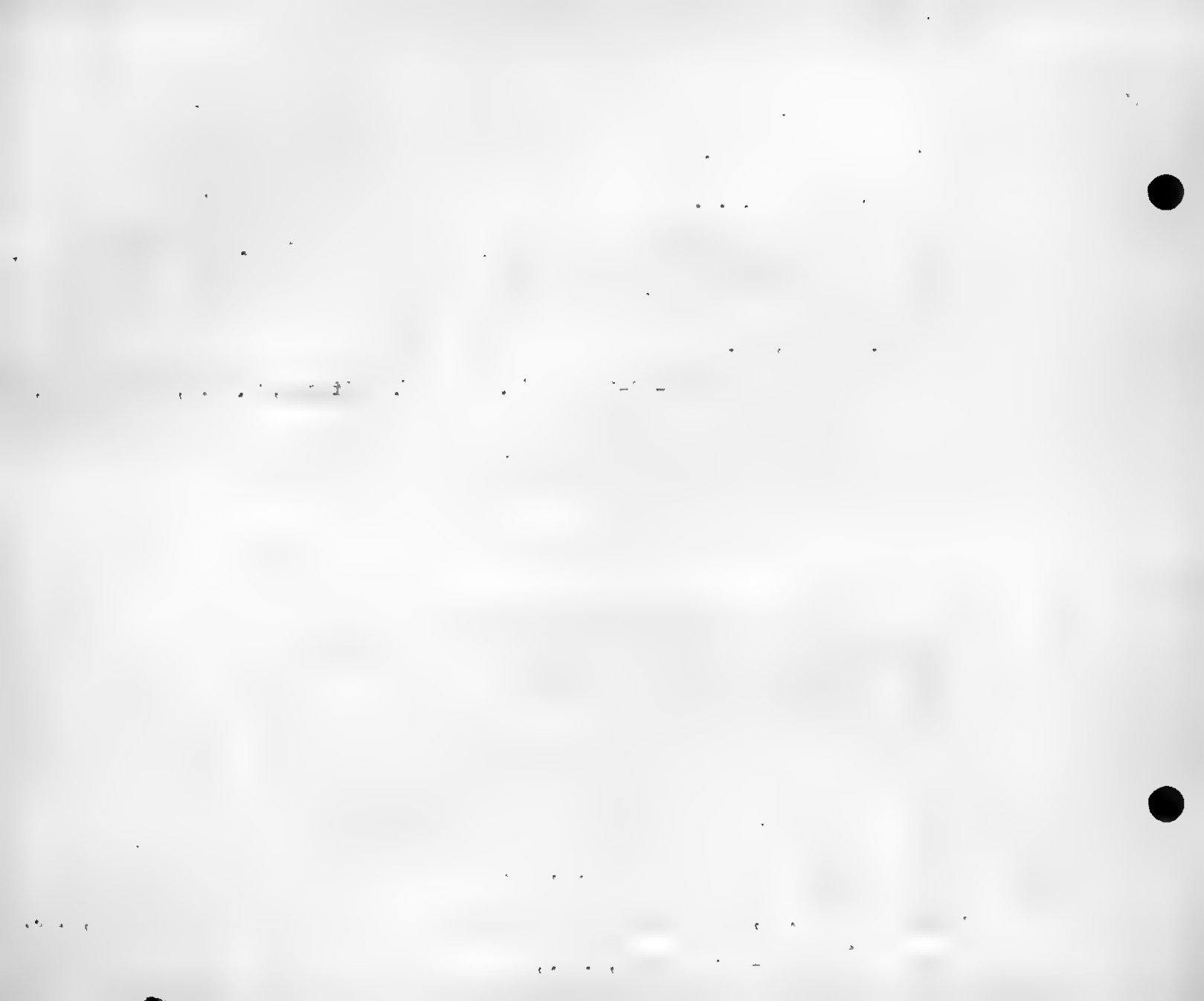


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

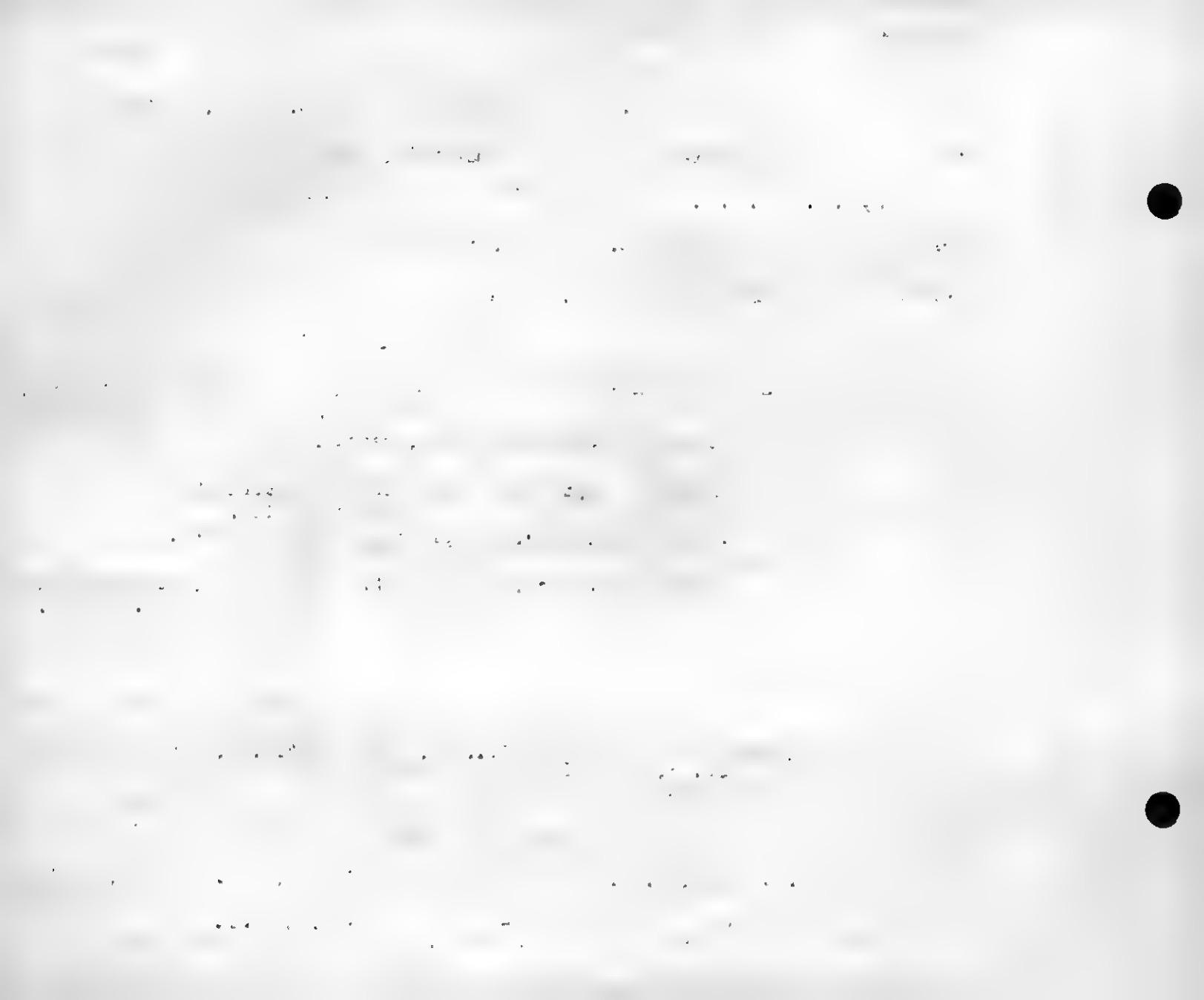
MARYLAND DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
Dorothy Virginia Whitacre						DATE KNOWN OF DEATH <input type="checkbox"/> Month Day Year <input checked="" type="checkbox"/> 2-20-68 191: 10pm M			
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		F UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Female	White	27 Oct. 1920	47 YRS	MONTHS	DAYS	HOURS	MIN.	Month Day Year	2d HOUR
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
West Virginia		U.S.A.				Prince George's Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Cheverly			Prince George Hospital			Cushion Dept.		Furniture Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) - STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
West Virginia			Martinsburg				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. 1, Box 229G
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
Edward A. Murphy, Sr.			Reba Hollar						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT ADDRESS			
No			No			235-12-1300 Mr. Herman J. Whitacre, Sr. Rt. 1, Martinsburg, WV			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Renal failure									
DUE TO, OR AS A CONSEQUENCE OF Necrotizing angitis									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
41									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			HOUR A.M. P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			ASSISTANT MEDICAL EXAMINER			2-20-68			
John Kehoe MD			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town or county)			
Riverdale, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		Feb. 23, 1968		Rosedale Cemetery		Martinsburg		Berkeley, W. Va.	
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard R. Brown			Brown Funeral Home-Martinsburg, W. Va.,			DATE FEB 23 1968		f Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card on paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

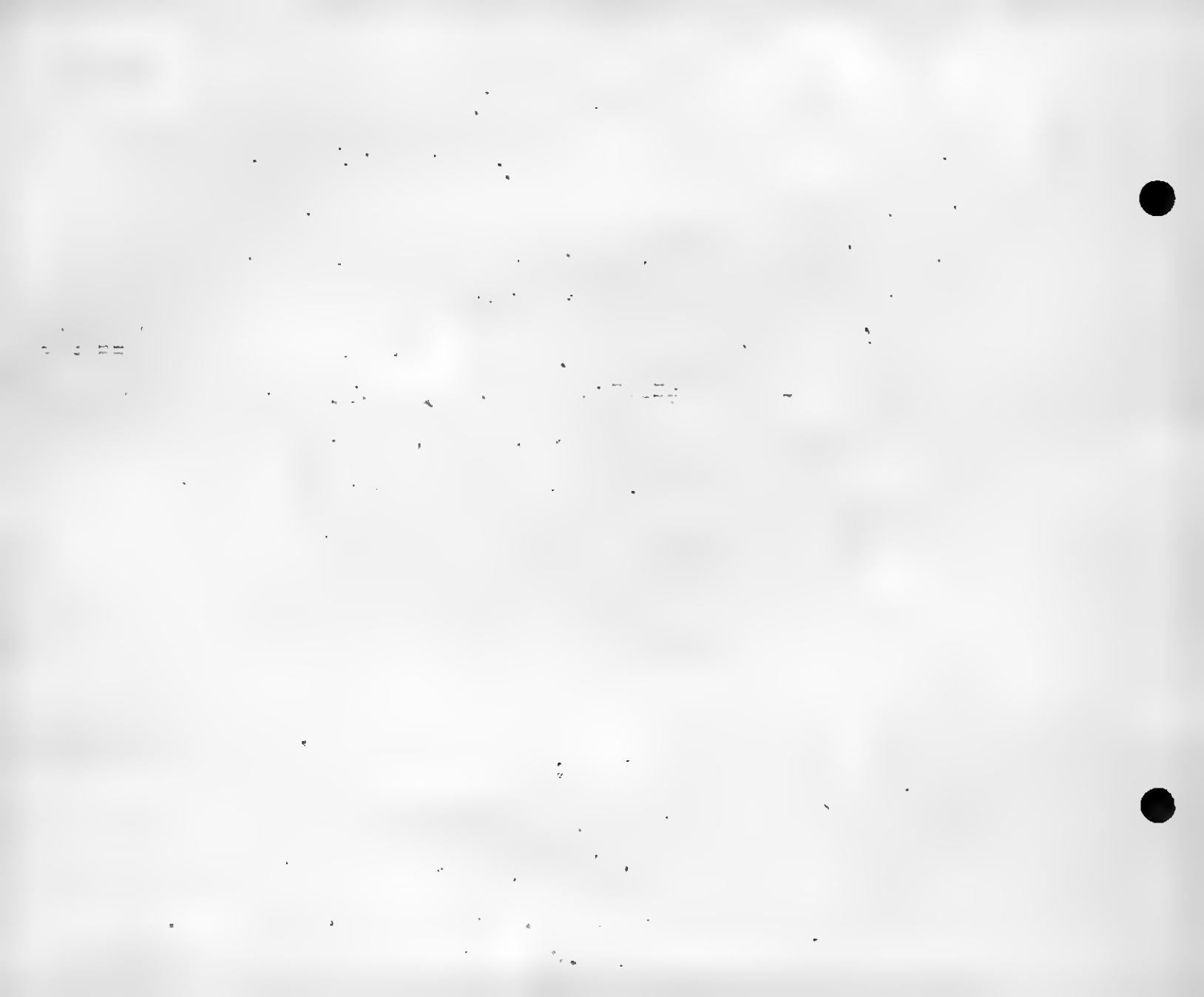
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR	
James H. Wight						Feb. 5, 1968		6 PM M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male		Caucasian		March 29, 1898		69 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH	
Wash., D.C.		U.S.A.				Prince Georges		Cheverly	
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Prince Geo. Gen'l Hospital		Carpenter							
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before 1950)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET AND NUMBER			
Maryland		Prince Georges		YES <input type="checkbox"/> NO <input type="checkbox"/>		3809 33rd Street			
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Fredrick L. Wight			Charlotte Bacon						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No			577-12-2193			Mrs. Julia R. Wight (above address)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bilateral pulmonary emboli, recent.									
DUE TO, OR AS A CONSEQUENCE OF (b) Abscess - right lower lobe with empyema, right pleural cavity.									
DUE TO, OR AS A CONSEQUENCE OF (c) Broncho-pneumonia, right, middle and upper lobes.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Recent infarction, right cerebral hemisphere, internal capsu-									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED CAUSES OF DEATH?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)		21f. LOCATION		Street or R.F.D. No.		City or Town	
22a. I certify that (I) (this hospital) attended the deceased from Jan. 18, 1968 to Feb. 5, 1968, that (I) (we) saw the deceased alive on Feb. 5, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE				22c. DATE SIGNED					
Don B. Cameron, M. D.				2-6-68					
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Don B. Cameron, M. D.				3503 Perry Street, Mt. Rainier, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		2/9/68		Glenwood Cem.		Wash., D.C.			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Nalley's Funeral Home Inc.				FEB 13 1968					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

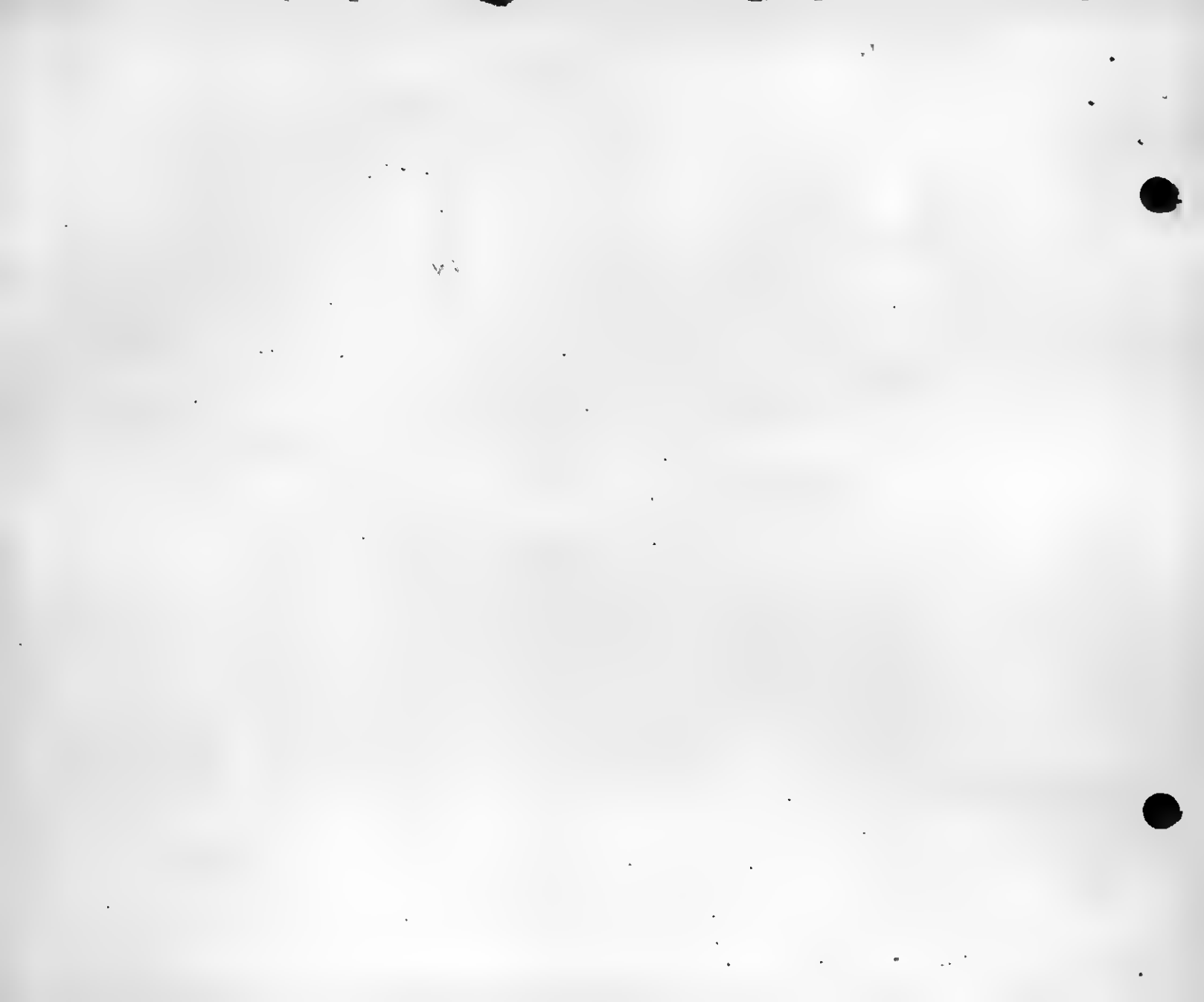
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) First Middle Last IDA BELLE WILKES					2a. DATE OF DEATH 2 Month 17 Day 68 Year			2b. HOUR 7:45 P M	
3 SEX FEMALE		4 RACE white		5. DATE OF BIRTH 1-29-1883		6. AGE (In years last birthday) 85 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Bath-n-Hudson NY		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Prince George Md.			
10. CITY OR TOWN OF DEATH Hyattsville		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) CARROLL MANOR-4922 La Salle		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY NONE			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Prince George		13c. CITY OR TOWN Hyattsville		13d. INSIDE CITY (MAY?) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 507 GREENDOWN DRIVE	
4. FATHER'S NAME First Middle Last John A Hockridge		15. MOTHER'S MAIDEN NAME First Middle Last GRACE Darling Burlingame							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 223-74-3711		17. INFORMANT Address Dr. Elizabeth - 4922 La Salle Rd.					
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 5101 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial infarction APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 34 hr									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from Jan 16, 1968, to Feb 17, 1968, that (I) (we) last saw the deceased alive on Feb 17, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Richard F. Shaw		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) DR RICHARD F. SHAW		22e. ADDRESS 1324 Mich. Ave NE							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2/20/68		23c. NAME OF CEMETERY OR CREMATORY Wash. Nat. Cem.		23d. LOCATION (City or Town) (County) (State) Suitland, Md.			
24. FUNERAL DIRECTOR Home Inc.				ADDRESS Mt. Rainier Maryland		25a. REC'D BY REGISTRAR DATE FEB 21 1968		25b. REGISTRAR'S SIGNATURE Charles Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>PRINCE GEORGES</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>RT 1 Box 292</u>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEO.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BRANDYWINE</u> d. STREET ADDRESS <u>RT 1 Box 292</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>BESSIE CLARA WILKINSON</u>						<b>4. DATE OF DEATH</b> Month Day Year <u>FEB. 1, 1968</u>											
<b>5. SEX</b> <u>FEMALE</u>		<b>6. COLOR OR RACE</b> <u>CAU.</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>JULY 29 1873</u>		<b>9. AGE</b> (In years last birthday) <u>94</u> yrs. <table border="1"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>DOMESTIC</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>PRINCE GEO. MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>									
<b>13. FATHER'S NAME</b> <u>FRANK COOKSEY</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZA COOKSEY</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>217-36-6610</u>		<b>17. INFORMANT</b> Address <u>ROBERTA WILKERSON BRANDYWINE, MD</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarct</u> <u>410.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>hypertension and atherosclerosis</u> DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 1/2</u>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>420.1</u>																	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>																	
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour (a.m. or p.m.) <u>6:15 A.M.</u> <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>					
<b>21. I certify that (I) (this hospital) attended the deceased from <u>10-30</u>, 19<u>67</u>, to <u>2-1</u>, 19<u>68</u>, that (I) (we) last saw the deceased alive on <u>2-1</u>, 19<u>68</u>, and that death occurred at <u>2-1</u> M, from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <u>Richard Dobson</u>										<b>22b. DATE SIGNED</b> <u>2-1-68</u>							
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>RICHARD DOBSON</u>						<b>22d. ADDRESS</b> <u>BRANDYWINE, MD.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>23b. DATE THEREOF</b> <u>2-3-68</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>ST. MARY'S CEM.</u>		<b>23d. LOCATION (City, town or county) (State)</b> <u>AQUASCO, MD.</u>											
<b>24. FUNERAL DIRECTOR</b> <u>HUNT FUNERAL HOME, WALDORF, MD.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>FEB 6 1968</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Lewis J. J.</u>									





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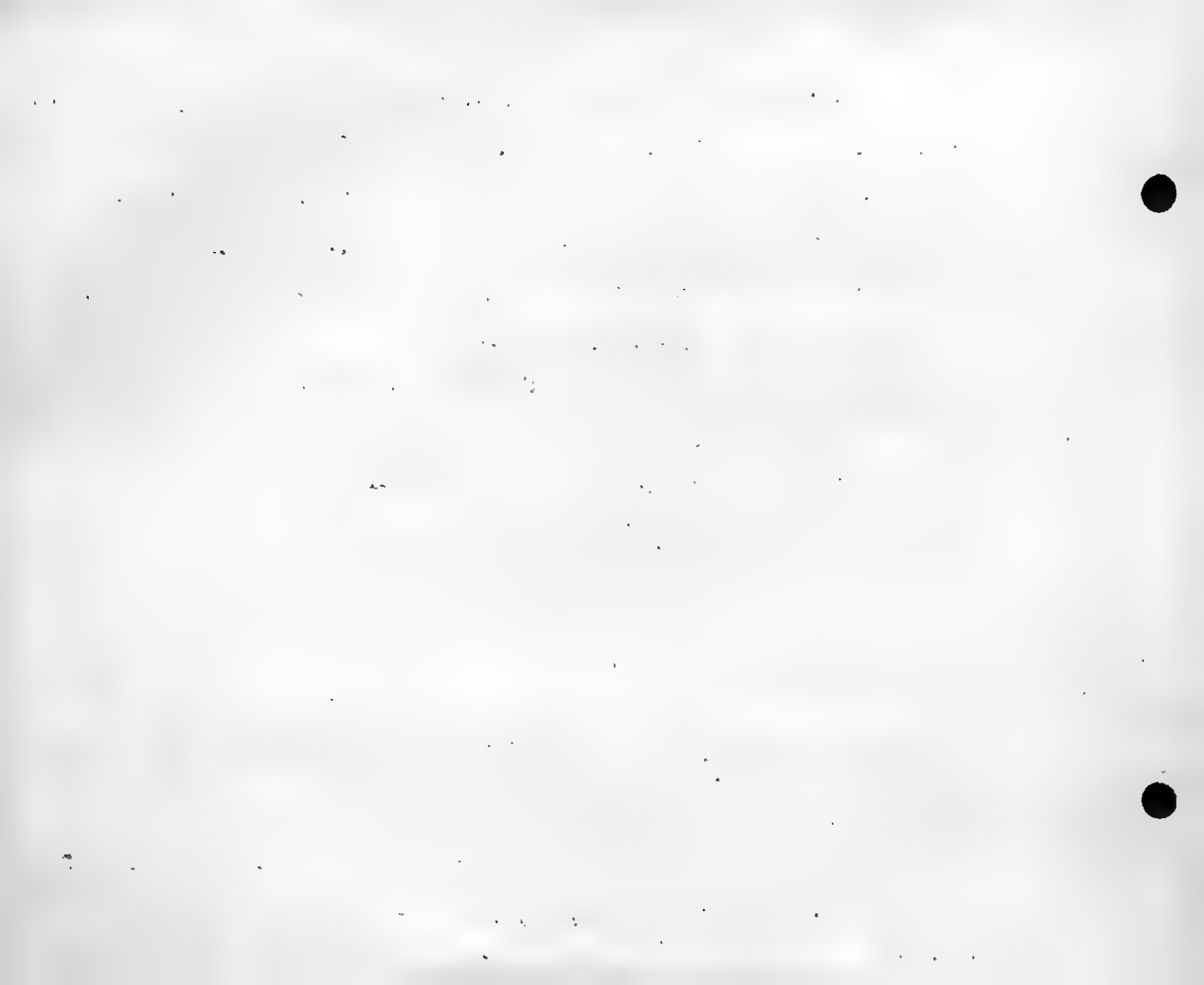
MARTLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First ELLA		Middle T.		Last WILLIAMS		2a. DATE OF DEATH Month FEB. Day 1 Year 1968		
3 SEX Female		4 RACE Cau.		5 DATE OF BIRTH 18 Dec. 1875			6 AGE (In years last birthday) 92 YRS.		2b HOUR 2:30 PM		
7a BIRTHPLACE (State or foreign country) Washington D C		7b CITIZEN OF WHAT COUNTRY? U.S.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH PRINCE GEORGE Md.					
10 CITY OR TOWN OF DEATH RIVERDALE		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 5901-63rd Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Secretary			12b KIND OF BUSINESS OR INDUSTRY Southern Rail.			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND		13b COUNTY PRINCE GEO.		13c CITY OR TOWN RIVERDALE		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 5901-63rd Ave.			
14. FATHER'S NAME First WILLIAM Middle H. Last WILLIAMS			15. MOTHER'S MAIDEN NAME First LAURA Middle N. Last TOMPKINS								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No		(If yes give war or dates of service)		16b SOCIAL SECURITY NO 704-18-1778		17 INFORMANT Barbara Halbritter Neice Same as Above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 427x DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from Dec 14, 1967, to 2-1, 1968, that (I) (we) last saw the deceased alive on 1-31-68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE Leonard Hays, M.D.				22c. DATE SIGNED 2-1-68		22d. PHYSICIAN'S NAME (Type) Leonard Hays, M.D.		22e ADDRESS 5203 Baltimore Ave. Hyattsville, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 2-5-68		23c NAME OF CEMETERY OR CREMATORY Congressional Cemetery		23d. LOCATION (City or Town) Washington		(County) D. C.		(State)	
24 FUNERAL DIRECTOR Francis Gasch's Sons				ADDRESS Hyattsville, Maryland		25a. REC'D BY REGISTRAR FEB 6 1968		25b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
GRACE			OLIVIA	WILLIAMS	FEB	Month	24	Day	1968
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR
FEMALE			WHITE		JUNE 24 1897		70		MONTHS
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
PENNA.			U.S.A.				PRINCE GEORGE'S		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
RIVERDALE			LELAND MEM. HOSP.			HOUSEWIFE			
13a. USUAL RESIDENCE (Where deceased lived, if institut on: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
MD.			PRINCE GEO.		RIVERDALE				4904 QUEENS BURY RD.
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First
JESSIE E.			HACKENBURG	MARTHA	HICKERNELL				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT			Address	
NO			579 22 7386		CARMEL E. WILLIAMS			SEE # 13 ABC E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1 DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Arteriosclerotic Ht Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Hypertension</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION									
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)									
21b. TIME OF INJURY									
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
21d. INJURY OCCURRED									
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)									
21f. LOCATION									
22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 1967</u> to <u>Feb 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>19 Feb 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE									
22c. DATE SIGNED									
22d. PHYSICIAN'S NAME (Type)									
22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify)									
23b. DATE									
23c. NAME OF CEMETERY OR CREMATORY									
23d. LOCATION (City or Town) (County) (State)									
24. FUNERAL DIRECTOR									
25a. REC'D BY REGISTRAR									
25b. REGISTRAR'S SIGNATURE									

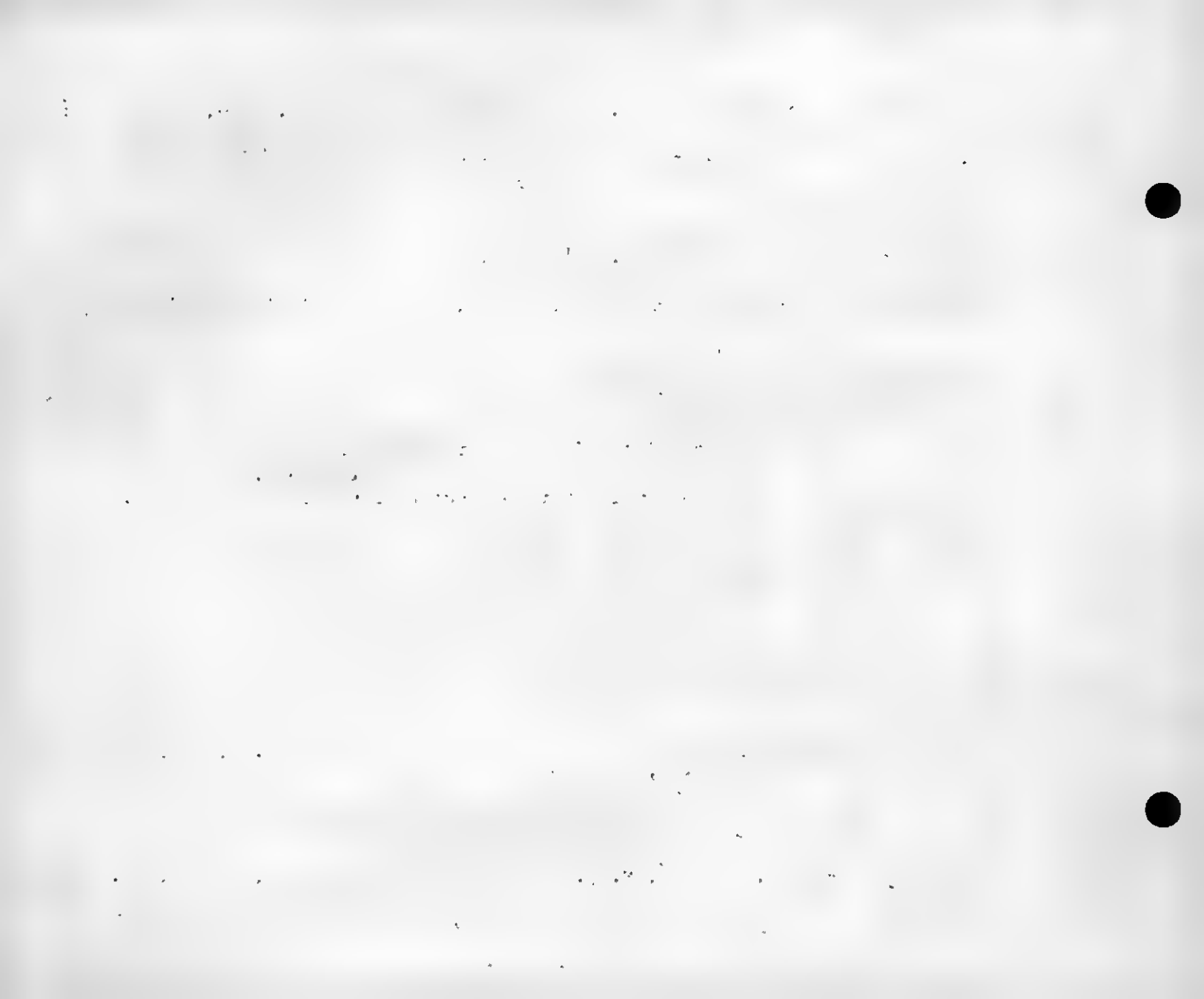


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VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Margaret H. Williams						Feb. 4, 1968			DOA 9:05A M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		Caucasian		Feb 20, 1910		57 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			10. CITY OR TOWN OF DEATH
Minnesota		U S A				Prince Georges			Cheverly
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Prince Geo. Gen'l Hospital		Budget Clerk		U S Government					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Prince Georges		Beltsville				12561 Gunpowder Road	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
John Miller						Mabel Galloway			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO		17. INFORMANT		Address		
no			577-40-9961		William J Williams		Beltsville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction with probable cardiac</u> <u>410.0</u> DUE TO, OR AS A CONSEQUENCE OF arrythmia. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease, long standing.</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (c) <u>420.1</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) <del>(the doctor)</del> attended the deceased from <u>Aug. 1967</u> to <u>Feb. 4, 1968</u> , that (I) <del>(the doctor)</del> last saw the deceased alive on <u>Feb. 4, 1968</u> , and that in my <del>(my)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(the doctor)</del> (did) <del>(did not)</del> view the body after death.									
22b. SIGNATURE <u>James W. Harding, M.D.</u>						22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type)	
James W. Harding, M. D.						6501 Riverdale Road, Lanham, Md. 20801			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		Feb 8, 1968		Ft Lincoln Cemetery		Colmar Manor		Pro Geo Md.	
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
F. Gasch's Sons					DATE FEB 9 1968		<u>[Signature]</u>		
Address Hyattsville, Md.									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

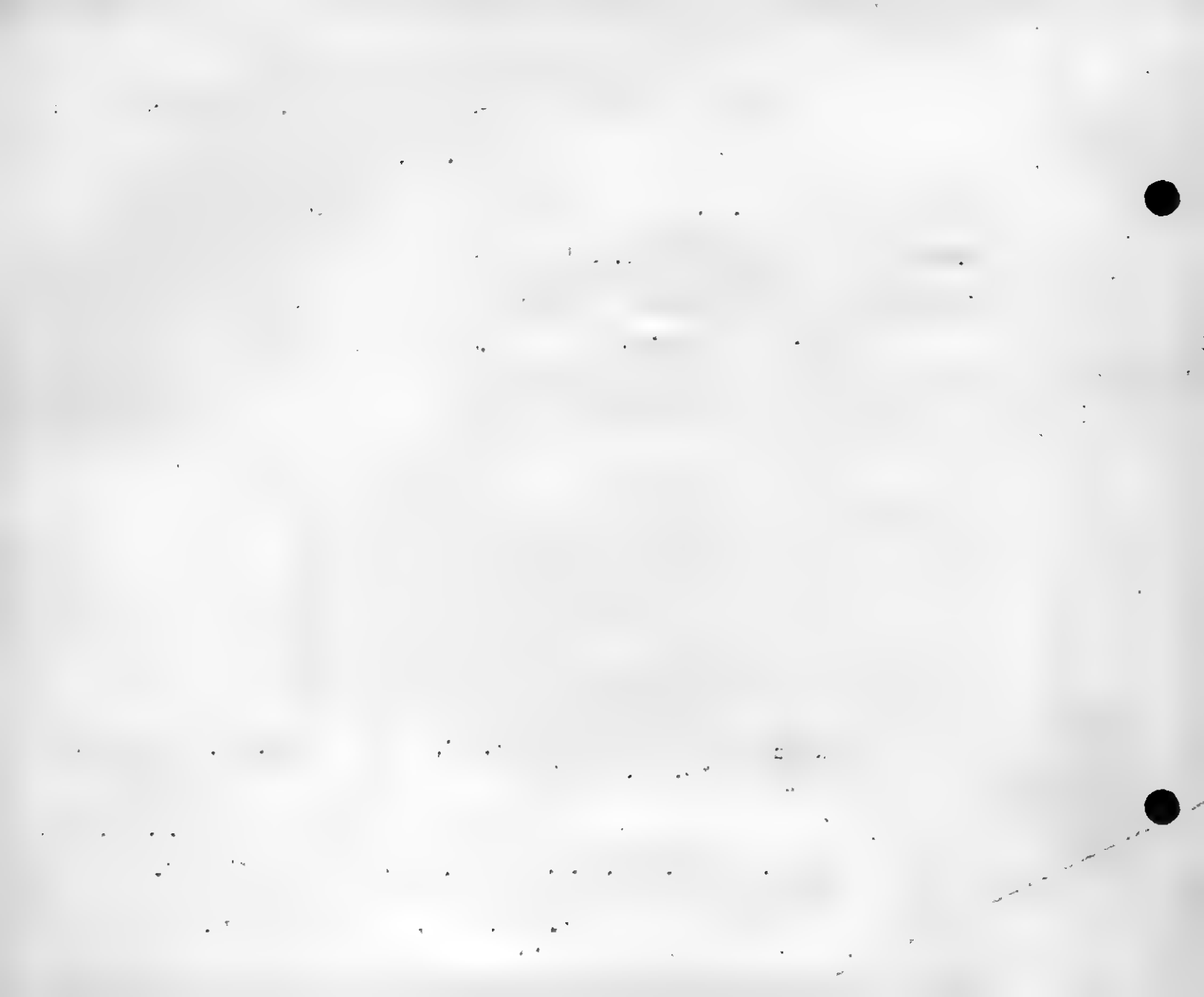
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Baby Boy Wilson</b>			2a. DATE OF DEATH <b>Feb.</b> Month <b>19</b> , Day <b>1968</b> Year			2b. HOUR <b>9:05 AM</b>			
3 SEX <b>Male</b>		4. RACE <b>Negroid</b>		5. DATE OF BIRTH <b>Feb. 19, 1968</b>		6. AGE (In years last birthday) <b>YRS.</b>		IF UNDER YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admssn) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Bowie</b>		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Box 305</b>	
14. FATHER'S NAME First Middle Last <b>James Wilson</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Thelma Lennett Morgan</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>mother</b> Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immaturity - 6 oz.</b> <b>1111X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>776x</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>Feb. 19, 1968</b> , to <b>Feb. 19, 1968</b> , that <del>he</del> (we) last saw the deceased alive on <b>Feb. 19, 1968</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>it</del> (we) (did) <del>do not</del> view the body after death.									
22b. SIGNATURE <i>John H. Moling, III</i>				DEGREE <b>MD.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>Feb. 20, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>John H. Moling, III, M.D.</b>				22e. ADDRESS <b>Prince Georges General Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>3/2/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Prince Geo. Gen. Hosp.</b>		23d. LOCATION (City or Town) (County) (State) <b>Cheverly, Md.</b>			
24. FUNERAL DIRECTOR <b>William A. Parker, Assoc. Administrator</b>				25a. REC'D BY REGISTRAR DATE <b>MAR 11 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

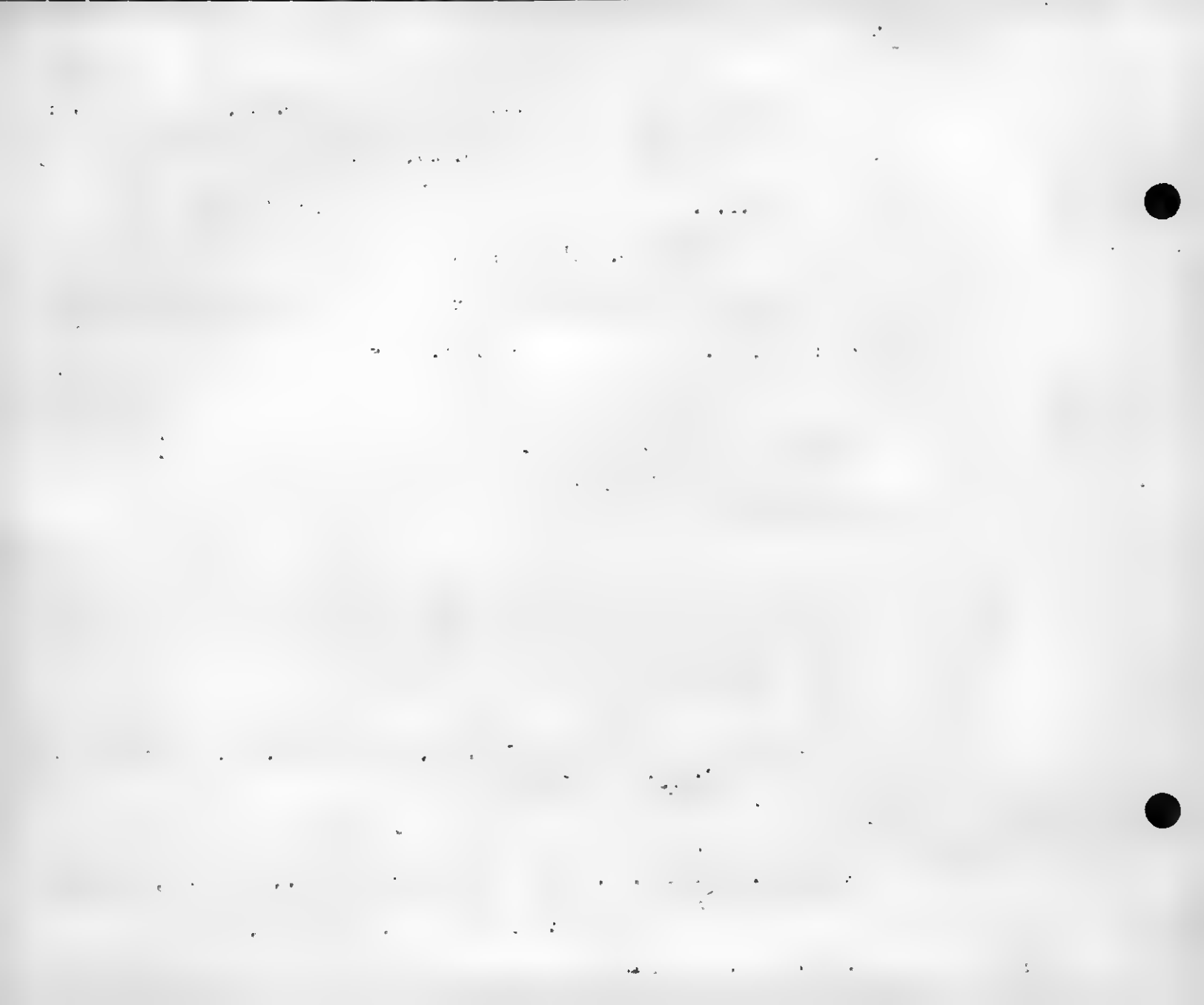




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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR P			
Baby			Girl	Wilson		Feb. 20, 1968		12:50 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS			
Female		Caucasian		Feb. 20, 1968		YRS		IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md			
Maryland		U.S.A.				Prince Georges					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Cheverly			Prince Geo. Gen'l Hospital								
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Prince Georges		College Park				9350 Cherry Hill Road		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Harold LeRoy Lewis, Jr.						Donna L. Wilson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Total Anoxia</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d)											
19a. DATE OF OPERATION											
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED											
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)											
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19											
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work											
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)											
21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from Feb. 20, 1968, to Feb. 20, 1968, that (I) <del>(we)</del> last saw the deceased alive on Feb. 20, 1968, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.											
22b. SIGNATURE <u>William R. Greco, M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22c. DATE SIGNED 2/26/68											
22d. PHYSICIAN'S NAME (Type) William R. Greco, M.D. 6201 Riverdale Rd., Riverdale, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify)											
23b. DATE 3/2/68											
23c. NAME OF CEMETERY OR CREMATORY Prince Geo. General Hosp.											
23d. LOCATION (City or Town) (County) (State) Cheverly, Maryland											
24. FUNERAL DIRECTOR ADDRESS Nanny W. Peon, Jr. Administrator											
25a. REC'D BY REGISTRAR DATE MAR 11 1968											
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

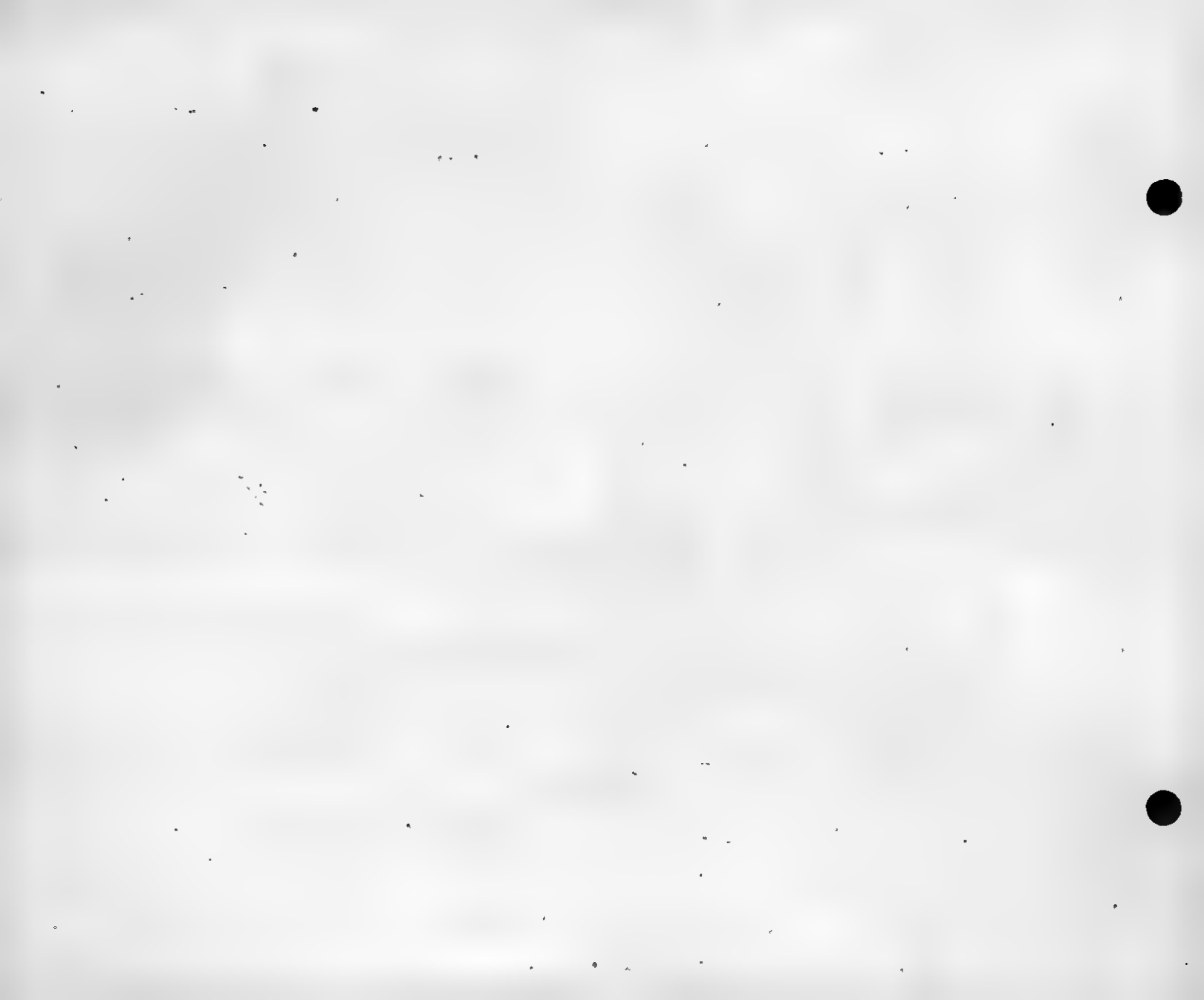


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) <b>First</b> <i>Adelle</i> <b>Middle</b> <i>T.</i> <b>Last</b> <i>Winant</i>			2a. DATE OF DEATH Month <i>Feb.</i> Day <i>4th</i> Year <i>1968</i>			2b. HOUR <i>4:45 PM</i>	
3 SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Aug. 1, 1896</b>		6. AGE (In years last birthday) <b>71</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Retired</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.	
10. CITY OR TOWN OF DEATH <b>Chesverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pro Georges Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired G P O</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Government</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institut an: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>Pro Georges</b>		13c. CITY OR TOWN <b>Brentwood</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>4309 34th street</b>		14. FATHER'S NAME <b>First</b> <i>Wm E</i> <b>Middle</b> <i>Thomas</i> <b>Last</b>		15. MOTHER'S MAIDEN NAME <b>First</b> <i>Kate</i> <b>Middle</b> <i>Maxwell</i> <b>Last</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Marjorie A Bachmann</b>		Address <b>Annapolis, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Heart Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>3 yrs.</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 min</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4001</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan. 26</i> , 1965, to <i>Feb. 4</i> , 1968, that (I) (we) lost saw the deceased alive on <i>Jan. 26</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Charles C. Hageage M.D.</i> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22c. DATE SIGNED <i>Feb. 4, 1968</i>			
22d. PHYSICIAN'S NAME (Type) <b>Charles C Hageage</b>		22e. ADDRESS <b>3308 Perry st Mt Rainier, Md.</b>					
23a. BURIAL CREMATON, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Feb 7, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons Hyattsville, Md.</b>				25a. REC'D BY REGISTRAR <b>FEB 8 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



FOR STATE  
HEALTH DEPT.

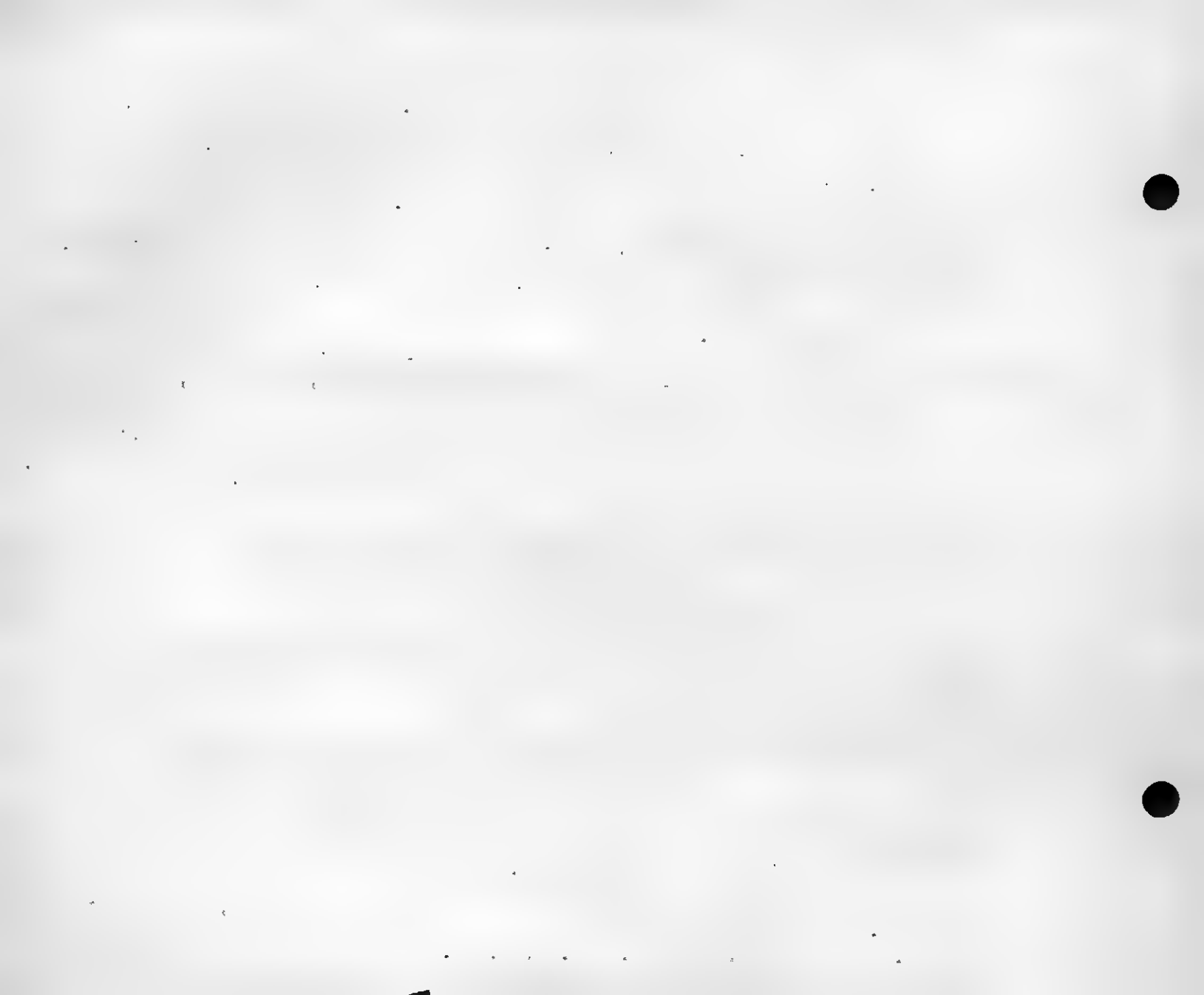
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and on any event within 72 hours after death.

Item 8 Film DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

3/4/68 ap 03120 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 2-19-68 191:00pm		2b. HOUR	
John		Andrew		Woofter Sr.							
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (in years last birthday)	F UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d. HOUR
Male	White	1-10-1907		61 YRS	MONTHS		DAYS		Month 2 Day 19 Year 68		5:40pm
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH				Md	
West Virginia		USA				Prince George's					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Riverdale		Ireland Memorial Hospital		Owner		Heating Air-Cond.					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Prince George's		Greenbelt				6122 Breezewood Drive			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
XXXXXX Frank XX		Woofter						unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give year or dates of service		16b. SOCIAL SECURITY NO		17 INFORMANT		ADDRESS					
yes		WW 11		291-01-6738		6122-Breezewood Drive		Roger Paul Woofter, Greenbelt, Maryland			
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart failure										minutes	
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic heart disease										over 3 yrs.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b)											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				2-20-68			
John Kehoe MD				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION REMOVAL (Specify)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial				2/23/1968		Crown Hill Cemetery		Hudson, Ohio			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Glen Carter						DATE FEB 23 1968		Charles Judge			
Warner E. Pumphrey, Inc. 8434-Ga. Ave. S. S. Md.											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03122

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>John V. Yeager</b>			2a. DATE OF DEATH Month <b>Feb.</b> Day <b>4</b> Year <b>1968</b>			2b. HOUR <b>8:20P M</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Dec. 8, 1923</b>		6. AGE (In years last birthday) <b>44</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____ IF UNDER 24 HRS. HOURS _____ MIN. _____	
7a. BIRTHPLACE (State or foreign country) <b>Wash., D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Prince Georges</b> Md.			
10. CITY OR TOWN OF DEATH <b>Cheverly</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Prince Geo. Gen'l Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Mgr. Loan Co.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b></b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Prince Georges</b>		13c. CITY OR TOWN <b>Bladensburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5628 Emerson St., Apt. B-1</b>	
14. FATHER'S NAME First Middle Last <b>John V. Yeager Sr.</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Frances Higdon</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WWII</b> (If yes, give branch or dates of service)		16b. SOCIAL SECURITY NO. <b>577-14-7855</b>		17. INFORMANT Address <b>Mrs. Mamie S. Yeager (above address) (Wife)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive Intracerebral Hemorrhage, right cerebral hemisphere</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis generalized</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>331X</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) <del>the hospital</del> attended the deceased from <b>Feb. 4, 1968</b> , to <b>Feb. 4, 1968</b> , that (I) <del>was</del> saw the deceased alive on <b>Feb. 4, 1968</b> , and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>will</del> (did) <del>not</del> view the body after death.									
22b. SIGNATURE <b>Leon Levitsky, M. D.</b>				DEGREE <b>MD</b>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <b>Leon Levitsky, M. D.</b>				22e. ADDRESS <b>3408 Rhode Island Ave., Mt. Rainier, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>2/7/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor, Md.</b>			
24. FUNERAL DIRECTOR <b>Nalley's Funeral Home Inc.</b>				ADDRESS <b>Mt. Rainier, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>FEB 9 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

1945 - 1946

1947 - 1948

1949 - 1950

1951 - 1952

1953 - 1954

1955 - 1956

1957 - 1958

1959 - 1960

1961 - 1962

1963 - 1964

1965 - 1966

1967 - 1968

1969 - 1970

1971 - 1972

1973 - 1974

1975 - 1976

1977 - 1978

1979 - 1980

1981 - 1982

1983 - 1984



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-2, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print)			First John			Middle D			Last Young			
3. SEX Male		4. RACE White		5. DATE OF BIRTH 4-23-1965		6. AGE (In years last birthday) 2 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Md			7b. CITIZEN OF WHAT COUNTRY? U S A			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Prince George's			
10. CITY OR TOWN OF DEATH Cheverly			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Prince George Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. CITY Prince George's			13c. CITY OR TOWN Seabrook			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 9522 Lanham Severn Road	
14. FATHER'S NAME First Norman L Young Sr			Middle Last			15. MOTHER'S MAIDEN NAME First Virginia J. Smith			Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --			16b. SOCIAL SECURITY NO. (If yes give war or dates of service) none			17. INFORMANT Norman L Young sr			ADDRESS Seabrook, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Laceration of brain</u> <u>818.1</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>And Fractures of cervical vertebrae</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>814.4</u>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>6:30pm</u> <u>2-23-68</u>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Fell out of car and struck by following car.</u>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Rt. 202 and 81st. Avenue, Prince George County, Maryland</u>				21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <u>John Kehoe MD</u> Riverdale, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)				22b. DATE SIGNED <u>2-24-68</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>Feb 28, 1968</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft Lincoln Cemetery</u>				23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor Pro Geo Md.</u>				
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.						25a. REC'D BY REGISTRAR DATE <u>FEB 29 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>				

1/10/70

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